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THE 1960's

-- A DECADE OF ADVANCE
IN REHABILITATING
THE MENTALLY ILL

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A REPORT OF PROGRESS AND PLANS FOR ACTION

U. S.
- by the Office of Vocational Rehabilitation
U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

September 1962

In his message to Congress on the health program, on February 27, 1962, President Kennedy emphasized that far more needs to be done in enlightened treatment of the mentally ill. This is an excerpt:

"...We are making progress, but the total effort is still far short of the need. It will require still further Federal, State, and local cooperation and assistance.

I have directed the Secretary of Health, Education, and Welfare, the Secretary of Labor, and the Administrator of Veterans' Affairs, with the assistance of the Council of Economic Advisers and the Bureau of the Budget, to review the recommendations of the Joint Commission on Mental Illness and Health and to develop appropriate courses of action for the Federal Government. They have been instructed to consider such questions as the desirable alinement of responsibility among Federal, State, and local agencies and private groups; the channels through which Federal activities should be directed; the rate of expansion possible in the light of trained manpower availabilities; and the balance which should be maintained between institutional and noninstitutional programs."

FOREWORD

One of our priority needs in rehabilitation in the 1960's will be the concentration of more of our talents and efforts on the rehabilitation of those who have been disabled by mental illness. We can look forward to a marked stepping up of services for the mentally ill on many fronts, particularly by state and Federal agencies.

There is also an urgent need for stepping up services for the mentally retarded. However, plans for the mentally retarded are the subject of another report currently underway and are therefore not dealt with in this report.

The crux of the recommendations made by the Joint Commission on Mental Illness and Health -- as they concern our rehabilitation efforts under the Vocational Rehabilitation Act -- is stated with remarkable clarity in the Joint Commission's summary of recommendations.

"Aftercare, Intermediate Care, and Rehabilitation Services.

The objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. Therefore, aftercare and rehabilitation are essential parts of all service to mental patients, and the various methods of achieving rehabilitation should be integrated in all forms of services, among them day hospitals, night hospitals, aftercare clinics, public health nursing services, foster family care, convalescent nursing homes, rehabilitation centers, work services, and expatient groups. We recommend that demonstration programs for day and night hospitals and the more flexible use of mental hospital facilities, in the treatment of both the acute and chronic patient, be encouraged and augmented through institutional, program, and project grants.

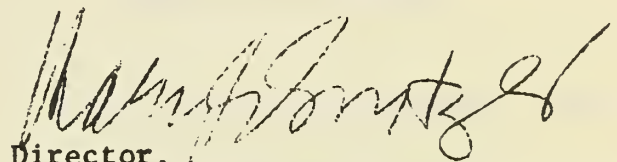
Aftercare services for the mentally ill are in a primitive stage of development almost everywhere. Where they do exist, services and agencies caring for the former patient tend to split off from mental patient services as a whole and further to approach the patient's problems piecemeal. Rehabilitation agencies should work closely with treatment agencies and preferably have representatives in the latter's institutional settings. It is important that rehabilitation be regarded as a part of a comprehensive program of patient services in which each and every member of the mental health team has a part to play."

The active interest in how to meet the problem of mental illness which this Department has by the very nature of its programs, has been expressed and demonstrated in any number of ways.

The Office of Vocational Rehabilitation issues the following report which constitutes an over-all plan for this Office to strengthen rehabilitation of the mentally ill in the remainder of the 1960's under the Vocational Rehabilitation Act. The report was prepared by a Task Force of members of the staff of this Office. It gives an account of the considerable accomplishments in the vocational rehabilitation of the mentally ill to date. It provides a useful reference on the subject. Most important, it suggests lines of intensified effort in the various parts of the total rehabilitation program including, as the core, the state rehabilitation programs.

I see this document as a total plan which we will be filling in over the course of the next ten years. We hope, for example, as one early step to develop in cooperation with the state agencies a suggested set of guides or standards as an aid in developing over-all plans for a state agency.

In addition to the efforts projected under the various sections of the Vocational Rehabilitation Act as amended, the Office of Vocational Rehabilitation is making plans to have available an increased number of specialized staff from both national and regional offices to provide professional consultation and assistance to those state rehabilitation agencies and community organizations which seek to move forward in psychiatric rehabilitation.

A handwritten signature in dark ink, appearing to read "M. H. Bontz", is written over the printed title.

Director,
Office of Vocational Rehabilitation

Rehabilitating the Mentally Ill

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The 1960's - A Decade of Advance
In Rehabilitating the Mentally Ill

Part I. Introduction

A. Why this report on progress and recommendations

This report presents an account of progress and a 10-year plan for a major, large-scale advance in rehabilitating the mentally ill under the authority provided in the Vocational Rehabilitation Act, with some revision of the present Act.

From time to time when we look at the picture of what the rehabilitation program is accomplishing for various disability groups, we find that the adequacy of rehabilitation services provided to a particular group is out of balance and needs adjusting. So with the mentally ill.

Despite a steady but modest rate of growth in the proportion of the mentally ill among the total number of disabled persons who are rehabilitated each year, there now is a clear call for a new thrust - with strong support to build resources of skilled manpower, facilities, programs providing services, and research and demonstration effort to fortify practice. It will take a concerted drive to advance rehabilitation of the mentally ill at a rate substantially greater than it is now advancing.

The report of the Joint Commission on Mental Illness and Health, "Action for Mental Health", has alerted the entire nation to the grievous lag in care and treatment of the mentally ill, and to the crying need for bold and vigorous action on all fronts. President Kennedy, in his message on the health program, expressed his approval of the State Governor's action in November 1960 pledging greater State effort, and he offered Federal cooperation. The President also called upon the Secretary of this Department and other major Federal officials to review the Joint Commission's recommendations and to develop appropriate courses of action for the Federal government.

This well deserves to be one of the foremost emphases of the public vocational rehabilitation program for the coming decade. This concerted effort in psychiatric rehabilitation will be designed to build the essentials so that rehabilitation of the mentally ill will proceed at sharply increased rates over the coming 10 years--coming closer each year to meeting the needs of this group. This is a recognition that rehabilitation of the mentally ill should reach by 1970 a much higher proportion among the total number of persons rehabilitated in the nation-wide vocational rehabilitation program.

B. The size of the problem

Because of the far-reaching effects of mental illness on family and social life as well as the economy of the nation, it is widely recognized as the Number One health problem.

Over half of the hospital beds in the United States are occupied by mental patients at any given time. Although there was a decrease of nearly 17,000 between the years 1956-1959, the patient load in the 277^{1/} public mental hospitals stood at 542,000 in December 1959. Only 29 percent of those hospitals were approved by the Joint Commission on Accreditation of Hospitals, which would indicate that most of our mental hospitals provide only custodial care. About 175,000 patients were released from public mental hospitals in 1959.

According to "A Survey of Mental Disease in an Urban Population", in Baltimore by the Commission on Chronic Illness, reported in October 1956, about one in every 10 persons is suffering from some form of well defined psychological disturbance or mental illness. Assuming that these findings are applicable across the country, an estimated 17,000,000 people in the United States fall into these categories. Even if - as the study observed - one out of five of these people were sufficiently well adjusted to maintain themselves independently in the community the figure is still staggering.

There are 1,429 out-patient Mental Health Clinics in the United States, unevenly distributed, but tending to follow concentrations of population. Of these, 48 percent serve children and adults, 30 percent serve children only, and 22 percent serve adults only. In 1959, total mental health clinic patients were estimated at 383,000, of whom 42 percent were children and 58 percent were adults.

The annual over-all cost of mental illness in the United States today is estimated as approximately \$4 billion dollars. ^{2/} Mental illness costs the Veterans Administration alone about \$844 million annually.^{2/} The estimated cost of public assistance to mentally ill and defective persons is \$32,432,400 per year.^{2/} Wages and salaries lost through absenteeism caused by mental illness in 1954 totaled an estimated \$60 million.^{2/}

In 1960 there were 11,787 psychiatrists in the United States, most of whom are in private practice, and a comparably small number of the other professional personnel traditionally engaged in mental health work.

From the above, the magnitude and complexity of the problem is apparent. As stated in the recommendations of the Joint Commission on Mental Illness and Health, it is equally apparent that "any national program against mental illness adopted by Congress and the States must be scaled to the size of the problem, imaginative in the course it pursues, and energetic in overcoming both psychological and economic resistances to progress in this direction."

^{1/} Figures for clinics include the Veterans Administration.

^{2/} "What Are The Facts About Mental Health?" published 1961 by National Committee Against Mental Illness. Other figures secured from National Institute for Mental Health.

C. Key needs and goals

The key needs and goals with which this advance must successfully contend are to develop money support, skilled manpower, and programs of rehabilitation services and procedures to:

- apply the considerable knowledge we have already tested and demonstrated
- evaluate our present procedures and discover and test new procedures, and from these to extract and apply the usable findings
- coordinate with other public and voluntary groups and efforts so that a sound and full program of rehabilitation services is available to the person disabled by mental illness, and
- educate the general public and more particularly special segments, such as employers, in the nature of mental illness and the rehabilitation potential of the mentally ill.

D. Basic assumptions

This call for a major and intensive acceleration in rehabilitating the mentally ill over the rest of this decade is based on these basic assumptions:

- Vocational rehabilitation - public and voluntary - is one of a community of programs that have important responsibilities in the nation's total effort to provide care, treatment, and rehabilitation of the mentally ill. The State vocational rehabilitation agency has an important role here that is unique - as both a provider of service and a coordinator.
- The task of developing, providing, and coordinating services to achieve the rehabilitation and job adjustment of the mentally ill, is a major concern and responsibility of this national program and its parts. This adjustment includes helping the mentally ill person to prepare for and to secure work, and helping him to continue in employment.
- The responsibility of the nation-wide vocational rehabilitation program to develop and to provide rehabilitation services for the mentally ill extends to
 - (a) the in-hospital patient and the post-hospitalized patient who need rehabilitation services on the way to resuming status in the community, and
 - (b) the mentally ill person who is not and has not been hospitalized and who needs help in order to stay in the community, outside the hospital.

-Such a major advance will grow along with the advance of two factors making the climate for growth more conducive: First, there will surely be significant progress in our knowledge about treating the mentally ill and in the kinds and quantity of services available for their total rehabilitation. Second, it is anticipated that there will be a notably rising level of money support for the public vocational rehabilitation program -- from Federal and State as well as from local public and voluntary sources.

-This call to action and recommendations to carry out the call have been designed to fit well into the proposals and the emphases urged by the Joint Commission on Mental Illness and Health.

Part II. Accomplishments to Date

A. The Beginning

The first venture of the public program into rehabilitation of the mentally ill was prompted by the enactment of Public Law 113 in 1943. This legislation broadened the program to include medical treatment and greatly increased the range of disabilities which could be served, including the mentally ill and retarded.

Thus vocational rehabilitation became the first State-Federal program authorized to provide direct services to individuals disabled by mental illness.

Moving out from a program geared exclusively to physically handicapped persons posed many new and difficult problems. Not until the end of World War II was there any perceptible movement by State vocational rehabilitation agencies into the problems of rehabilitating the mentally ill.

Very early it was evident that counselors working with psychiatrically disabled persons needed special preparation.

To the extent they were financially able, the States provided short-term in-service training. A number of State agencies employed part-time consulting psychiatrists to help counselors in evaluating cases and to assist in the training programs. A few employed psychiatric social work consultants.

In spite of these efforts, the reluctance to approach the hospitalized patient continued to pose the greatest problem. This was reflected in the 1945 rehabilitations: 55 had a diagnosis of psychosis and 1,230 were psychoneurotics.

In 1947 the National Committee for Mental Hygiene (now the National Association for Mental Health), a sturdy ally in promoting the passage of Public Law 113 which revamped the Vocational Rehabilitation Act in 1943, undertook a study of vocational rehabilitation needs of post psychotic patients who had been hospitalized and were ready to return to the community. The study, made in New York Connecticut and Michigan, was published in 1950. The findings indicated that about 15 percent of the patients leaving the hospital needed and could use vocational rehabilitation services. Later studies under our research program have tended to confirm this figure, though some believe this percentage may be as high as 40 percent. It would be worth devoting research effort to this subject, to show the size of the potential rehabilitation workload among the mentally ill.

The findings of another study, by Rennie and Bozeman, on vocational services for psychiatric clinic patients, published for the Commonwealth Fund in 1952, lend support to the need to extend vocational rehabilitation services to high school and college students who have psychiatric handicaps.

B. Progress

In 1952 and again in 1953 the National Institute of Mental Health made funds available to three universities for training vocational rehabilitation counselors. The courses were for two weeks the first year and as a follow-up, for one week the following year. Stimulation of interest, increased insight and understanding were observable benefits in the performance of those who had this opportunity.

By 1954, a majority of the State agencies had designated certain counselors to work with State mental hospitals, some on a full-time basis. The practice of serving the emotionally disturbed who had not been hospitalized continued.

The number of mentally ill persons who were rehabilitated had shifted by 1954 to 585 with a diagnosis of psychosis, and 1,123 with psychoneurosis. Counselors were beginning to work with what might be assumed were the more difficult cases.

By this time also, the urgent need for a legislative framework which would greatly expand the entire scope of operation for the vocational rehabilitation program came to the fore. Public Law 565 was the result.

At the same time the rising national concern over constantly increasing numbers of patients in mental hospitals and obviously ineffectual treatment had brought this problem squarely before State governments and the Congress.

In general Public Law 565 authorized: (1) increased financial support of vocational rehabilitation by the Federal government and the States; (2) support for more and better rehabilitation facilities and workshops in which to provide services; (3) a training program to increase the supply of professional personnel who provide rehabilitation services; and (4) support of research studies and demonstration projects to discover and prove new methods and techniques to improve the quality of rehabilitation services.

Progress in the rehabilitation of the mentally ill has come with the impetus this new legislation provided.

C. Where We Are Today

1. Basic Program

The impact of new monies and new opportunities within the program after the 1955 legislation has been readily apparent. In the years 1956-1961 a total of about 26,100 persons with psychiatric disabilities were rehabilitated. About 6,400 were rehabilitated in 1961, and an estimated 7,350 were rehabilitated in 1962. Beginning in 1958, those rehabilitated with a diagnosis of psychosis have each year outnumbered those with psychoneurosis.

Some State agencies have developed substantial programs of services for the mentally ill under their regular basic services programs, with financing under section 2 of the Vocational Rehabilitation Act. Some of these agencies were already moving forward at a satisfactory rate of increase. Some have been unable, because of limited State appropriations, to take advantage of project opportunities under the new legislation, mainly extension and improvement project grants.

This new type of project grant introduced by Public Law 565 provided an incentive to State agencies to undertake projects to improve and extend rehabilitation services. These projects, with Federal matching up to 75 percent, have a maximum duration of 3 years, at the end of which it is expected that the activity will be absorbed into the State's ongoing program. Through fiscal year 1961 there were 49 such projects involving the mentally ill. (See Appendix 2)

In the years 1956 and 1957, Section 4(a)(2) of the Act authorized grants to States or other public or nonprofit organizations for a substantial expansion of vocational rehabilitation programs, either through direct services to individuals or establishing facilities. Five such grants involving the mentally ill were made. (See Appendix 3)

A majority of the State agencies are assigning counselors to State mental hospitals. Leading the way, some State agencies have moved to set up rehabilitation units within state mental hospitals. Others have taken steps to build a plan for a major program emphasis in this phase of rehabilitation, including staff specialists in psychiatric rehabilitation. One State, with a strong emphasis on rehabilitating the mentally ill, pioneered in operating half-way houses financed under sections 2 and 3 of the Vocational Rehabilitation Act, which then became the model for a series of demonstration projects.

These are good beginnings, from which a major push can be launched.

2. Training

The greatest single obstacle to providing rehabilitation services to more disabled persons is the acute shortage of trained personnel - psychiatrists, nurses, occupational, physical, and speech therapists, counselors, social workers, psychologists and those in other professions involved in the provision of effective rehabilitation services.

With the passage of Public Law 565, the Office of Vocational Rehabilitation made plans to do something about the immediate need for a greatly accelerated and broadened program of short-term training of personnel concerned with psychiatric rehabilitation. There was particular emphasis on better channels of communication between the hospital and the State vocational rehabilitation agency.

OVR has not undertaken long-term training of psychiatric personnel because of the very extensive program for such training under the National Institute of Mental Health.

A series of regional workshops - supported by OVR - was undertaken, designed to bring together not only staff from the vocational rehabilitation agencies but State hospital and mental health personnel. To date all nine regions have been covered once, with repeats in four regions.

The results of these workshops have been most encouraging. Hospitals which heretofore had indicated little interest in a program of vocational rehabilitation have now requested assistance from the vocational rehabilitation agency. Referrals have increased consistently and cases have been more carefully evaluated prior to referral. Similar workshops have been held in individual states.

Most of the extension and improvement projects carrying State agency services into the hospitals have been a direct outgrowth of these workshops, and a major portion of the research and demonstration projects in the field of mental health originated from discussions taking place on these occasions.

In addition to these workshops, lasting 3 or 4 days, grants have been made to universities and institutions for three- or four-week training courses on a national level for rehabilitation personnel working with the psychiatrically disabled. (See Appendix 4)

OVR is now supporting the employment of a consultant in occupational therapy for psychiatric patients.

The need for more substantial and intensive training for counselors working with the mentally ill, especially those in hospitals, has become increasingly evident. As programs for vocational rehabilitation in hospitals have expanded, the selection of suitable personnel has become more critical.

In an effort to resolve this problem, the Office of Vocational Rehabilitation is developing a program of internships of 6 months duration for vocational rehabilitation counselors in selected hospitals affiliated with medical schools. Teaching and traineeship grants will be made to the schools. Appropriate faculty together with professional staff of the hospital will develop a suitable curriculum both academic and clinical.

Three schools have been approached for fiscal year 1963 and should be ready to receive applications for traineeships by early fall. State agencies are being notified well in advance in order that counselors currently employed and interested in working with the mentally ill and emotionally disturbed may take advantage of this opportunity.

It is important to recognize in this context that OVR is currently contributing to the supply of skilled manpower in psychiatric rehabilitation, through grants for basic professional training in psychology, social work, rehabilitation counseling, occupational therapy, and rehabilitation nursing.

3. Research

About \$3 million of some \$26 million in Federal grants for research and demonstration has been awarded to 54 projects concerned with rehabilitation of the mentally ill. (See Appendix 5)

Some of the most imaginative and creative work in rehabilitation today is being carried on under this program. These projects cover a variety of rehabilitation activities and many different categories of disability.

These projects for the mentally ill have dealt with establishing, developing community use, and improving the therapeutic and vocational rehabilitation techniques of (a) the rehabilitation-oriented therapeutic community hospital, (b) the day hospital, (c) the half-way house, (d) work therapy in the hospital and in related workshop facilities, (e) screening of hospital cases for rehabilitation potential, (f) out-patient counseling and rehabilitation after-care, (g) evaluation, work training, and intensive placement for emotionally disturbed persons. In two of these areas a series of demonstration projects patterned on a model project has been developed - the half-way house and the evaluation, work training, and intensive placement for the emotionally disturbed person.

Several published final reports of OVR-supported research projects are now available. These reports, listed in Appendix 6, include projects on (a) the functions of a comprehensive vocational evaluation and preparatory program in a private psychiatric hospital, (b) the nature of the program in a fully rehabilitation-oriented State psychiatric hospital, and (c) the functions of the day hospital as part of a comprehensive psychiatric program.

4. Facilities

Seven research and demonstration project grants have been made to facilities, to develop programs of rehabilitation of the mentally ill. These reflect the growing tendency of serving multiple disabilities in rehabilitation centers. These have been a type of demonstration project series with a major purpose of building wider understanding of new and more effective rehabilitation methods by introducing these methods into on-going programs of existing agencies.

Nine of the 49 extension and improvement projects through 1961 established special rehabilitation facilities to serve hospitalized mental patients. One established a Rehabilitation House for post-hospitalized patients. (See Appendix 7A)

The construction of eight rehabilitation facilities for the rehabilitation of mental patients has been approved under the Medical Facilities and Construction Act (Hill-Burton). All are in operation except the Psychiatric Unit and Rehabilitation Center which will be in Ponce, Puerto Rico. (See Appendix 7B)

The establishment of ten rehabilitation facilities under the basic support program has been reported to the Office of Vocational Rehabilitation. Since specific reporting of these items has not been required, this number may actually be higher. (See Appendix 7C)

Part III. Recommendations for Action

A. Main Avenues of Progress

To build toward the goal of better balance for rehabilitation services to the mentally ill, we must concentrate our efforts in the next 10 years on selected areas of emphasis.

To achieve this, we must direct and use intensively all available resources to these main avenues:

- to build skilled manpower sources
- to build community facilities and programs of rehabilitation services for the mentally ill - in and out of hospitals - with practical emphasis on rehabilitation with a vocational goal
- to help the State vocational rehabilitation agencies build their programs to rehabilitate increasing proportions of the mentally ill, and
- to build public understanding and cooperation in dealing with mental illness as a disability and in realizing the rehabilitation potential of the mentally ill.

To achieve this, we must also plan to commit to this purpose a substantially reinforced OVR staff, sufficient in numbers and expertise to give active leadership in rehabilitating the mentally ill. State rehabilitation agencies and many community organizations will need assurance that they will have access to professional consultation and assistance if they are to move forward on such plans as these. OVR staff should be strengthened in the central office as well as in the regional offices with specialist staff to give leadership and support to these agencies in this effort.

These Recommendations for Action are designed on the premise that OVR must provide leadership and support for priority actions in a coordinated pattern, that takes into account both the immediate, major need exemplified by the in-hospital population and the needs of the out-of-hospital group of both ex-patients and non-patients. This Report includes a selected group of plans of first priority, and another set with lesser priority.

B. Building Manpower

The core of any advance in rehabilitating the mentally ill is skilled manpower. Certainly the success of any intensive advance of this kind will hinge on the skilled manpower support that can be brought to bear in the effort.

Recommendations of First Priority

- OVR should devote substantially higher proportions of its total training appropriation each year to training in psychiatric rehabilitation.

By 1966 the total amount for this purpose should be between \$600,000 and \$800,000.

By 1970, we should reach a level of money support in long and short-term training that we can sustain, in order to keep up the needed flow of skilled manpower into psychiatric rehabilitation.

Within this total increase there should be substantial growth each year in OVR support for short-term training in psychiatric rehabilitation, beginning with a base of about \$85,000 in 1963.

- OVR should build up an internship program in rehabilitation counseling at selected hospitals with active psychiatric rehabilitation teams in residence, mental health clinics or other suitable settings. Building from the start made in fiscal year 1963, by 1970 we should have a nucleus of at least 80 counselors with such special training. To assure maximum results, OVR-sponsored training should also support a social worker member of the team in these programs.

A comparatively small number of rehabilitation counselors are now prepared professionally to work with the mentally ill. Few State rehabilitation agencies have been able to assign qualified counselors to State and private mental hospitals in sufficient numbers to be influential in helping to reduce the inpatient load or to work as part of the institution's psychiatric team.

- State agencies should be given all possible encouragement and support to build staff specializing in psychiatric rehabilitation. This should include Federal support under section 4(a)(1) (or possibly an amended version of section 3 of the Vocational Rehabilitation Act applicable across the board in all projects), to provide more liberal Federal matching for as much as 90 percent of the annual salary of such staff for a maximum of 3-5 years. Such support should be given, for example, for at least one specialist in the State office and in succeeding years a small nucleus of specialist counselors, psychiatric social workers, or other client service personnel. This support should be available also for staff to provide psychiatric consultation to counseling staff.
- OVR should support and join other agencies such as the NIMH in supporting a comprehensive system of short-term courses and institutes in psychiatric rehabilitation for the professional development of staff already employed in the rehabilitation field, to reach all levels of personnel and all regions.

Priorities should be established for short-term training for the following groups of personnel:

- vocational rehabilitation counselors
- State rehabilitation agency directors and supervisory staff
- social workers
- psychologists
- medical and psychiatric consultants to State agencies
- placement staff of State agencies, rehabilitation facilities, and industrial establishments
- workshop supervisors
- halfway house personnel
- public health, psychiatric, industrial and school nurses
- physical and occupational therapists
- industrial therapists
- industrial health staff
- community psychiatric clinical staff
- nursing home operators
- secondary public school staff

In 1962-1963 a meeting of the rehabilitation counseling grantees should be held to plan toward inclusion of a more comprehensive approach to mental illness in the curricula content and the internship programs of these schools.

Special short-term courses or institutes should be held for the purpose of interpreting significant findings of research and of demonstration projects to State vocational rehabilitation agency and other staff engaged in rehabilitating the mentally ill.

- Films, live drama presentations, and other recruitment materials should be developed by the OVR to focus the attention of young people making career choices on those health professions dealing with the total rehabilitation of the mentally ill.
- Volunteers of both sexes should be used in rehabilitation efforts for the mentally ill, in ways to be developed through joint efforts in training and research. Volunteers should be used particularly to help those who have been patients in hospitals - to bridge the gap between hospital and community life. Local mental health associations can initiate this kind of training, in hospital, clinic or university settings.

Other Recommendations

Social Work. The psychiatric content of training for social workers should be further strengthened in the area of rehabilitation. This would form the basis for the use of social workers in a fee or contract basis by State rehabilitation or other agencies, to provide needed counseling to the ex-patient and his family.

Physical Therapy. The role of the physical therapist in treatment of the mentally ill should be expanded and the school curriculum should be strengthened in this respect. Emphasis should be placed on prevocational evaluation and work tolerance programs.

A workshop should be planned on (a) what is now being done to use physical therapists in psychiatric settings and (b) what curricula changes may be indicated.

Occupational Therapy. In line with emphasis on psychiatric work in the curricula of occupational therapy schools, OVR should expand the graduate traineeship program for the psychiatrically-trained occupational therapist.

OVR should look to the pilot training programs for occupational therapy assistants which it is now sponsoring, for a pattern to be given wider application.

Physiatrists and Psychiatrists. Training opportunities for physiatrists should enable them to become more knowledgeable about mental illness, its relation to physical disability, and the rehabilitation of the mentally ill.

Training opportunities should be developed in cooperation with NIMH, to enable psychiatrists to become more knowledgeable about the therapeutic modalities of physical and occupational therapy, work evaluation procedures, and the physical and mental requirements of various occupations.

Nursing. The OVR, in cooperation with the National Institute of of Mental Health, should encourage and support training efforts to help nurses in various settings like those in psychiatric, public health, industrial and occupational health, and school settings, to gain awareness of their responsibilities in rehabilitation of the mentally ill. This should include short-term training programs and more specific rehabilitation content in graduate programs for nurses.

Therapeutic Recreation. The role of the trained recreational therapist in rehabilitating the mentally ill should be developed, and the OVR should support efforts to build psychiatric content in the curriculum for this field.

C. Building Community Facilities and Programs of Service. The two dominant needs for facilities and programs of service are:

1. the need to build vocational rehabilitation content into (a) hospitals for the mentally ill and (b) transitional and aftercare facilities which need to be developed in a wide variety of forms, and
2. the need to fortify rehabilitation procedures for the mentally ill through (a) research and demonstration and (b) the dissemination and application of research findings to services for the mentally ill.

The report of the Joint Commission on Mental Illness and Health underscores in many ways the serious shortage of facilities of all kinds to give care and rehabilitation treatment to the mentally ill. Accompanying the shortage of facilities are short-comings in existing programs to provide services to the mentally ill and in our knowledge about how to serve them.

The range of project and basic support program grants authorized by the Vocational Rehabilitation Act, plus the grants available to aid construction of rehabilitation facilities under the Medical Facilities Survey and Construction Act (Hill-Burton) should be major channels of support for the development of facilities to serve the mentally ill over the next ten years.

Under the Vocational Rehabilitation Act, the growth of facilities should be given greater support and encouragement through grants for projects of the following kinds: research, demonstration, selected demonstration, training, extension and improvement, and expansion-type.

As a major spur to increase and improve facilities to provide rehabilitation services to the mentally ill, there should be a revival of expansion-type grants to cover projects for preparing, planning, or initiating program expansion in rehabilitation of this group. These grants should cover part of the cost of construction or alteration, and staffing, equipment, and operating costs for an initial period not to exceed 3 years. This recommendation is more fully developed under Section F.

In planning for various kinds of projects to advance psychiatric rehabilitation, it will be important to include distinctly different types of effort - all of which will be needed in the development of community facilities and programs of service. Some projects will deal with developing and testing new methods and programs of service; others will be part of a group of demonstrations to give wider application to a special emphasis; and still others will extend or improve existing facilities or programs or set up new, additional facilities along an existing pattern.

Recommendations of First Priority

- Half-way houses of different kinds for post-hospital and for preventive care should be supported by OVR as a major emphasis. Support should be extended through all the means available under the Vocational Rehabilitation Act, including research, demonstration and training grants, extension and improvement grants, expansion-type grants for preparing, planning or initiating program expansion, and the basic support program funds under section 2 of the Act.

In the years up to 1966, OVR should emphasize support of the establishment of new facilities of this kind and on research and demonstration, stressing new efforts, the provision of services, and new ways to use these transitional facilities.

Beginning in 1966, OVR should cooperate with the NIMH in conducting a coordinated study of the effectiveness of the various types of half-way houses in the nation in promoting reintegration of mentally ill persons into community life.

At least 10 to 15 half-way houses should be supported under research and demonstration grants in each of the next three years. Support under extension and improvement grants should

be given to a comparable number of project efforts. Expansion-type grants averaging between \$15,000 and \$20,000 a year should be awarded in progressively larger numbers each year, beginning with 50 in the field of mental illness in 1964 - the first full year in which new legislation might be effective - and increasing to 150 in 1966. This level should be sustained through 1970. Support of half-way houses should also be given under the basic program under section 2 of the Vocational Rehabilitation Act for establishment and purchase of services.

Half-way houses with expanded and coordinated services should be established. This kind of house would add to the usual residential facilities a systematically planned and unified program of vocational training, psychiatric consultation, casework service, and therapeutic group activities, in a community setting.

- OVR should have as an equally major emphasis the support of in-hospital rehabilitation units. The primary objective here should be the establishment of such units, mainly by the State vocational rehabilitation agencies, for initial periods, on the assumption that the provision of these services will ultimately be absorbed as part of the hospital's on-going program.

As in the case of the emphasis to be accorded half-way houses, OVR support of the establishment of in-hospital rehabilitation units should make as full use as possible of the varied authority under the sections of the Vocational Rehabilitation Act, as amended.

- OVR should encourage and support rehabilitation facilities, e.g., rehabilitation centers, workshops, including personal and work adjustment workshops and specialized facilities, in their efforts to serve increasing numbers of the mentally ill, especially with tie-ins to hospitals and mental health clinics.
- OVR should take initiative in launching demonstration and prototype series of demonstration projects for encouraging the establishment of:
 - a. procedures in psychiatric clinics for referring to community rehabilitation facilities the mentally ill who have not been hospitalized, with emphasis on serving those over 16. Existing clinic resources now concentrate heavily on serving (1) adults who have been hospitalized, and (2) children.
 - b. rehabilitation sections in psychiatric units of general hospitals.
 - c. day care centers or social organizations to aid the mentally ill in social adjustment so essential to satisfactory job performance.
 - d. a tie-in between State vocational rehabilitation programs and social organizations such as Fountain House in New York City, and emergency care services such as Suicide, Inc.

-- OVR should encourage and support research, and the dissemination and the application of research findings in these priority areas:

- a. experimentation with and evaluation of various types of (1) in-hospital rehabilitation arrangements, (2) day and night hospitals, (3) half-way houses, (4) day care and social centers, (5) work adjustment facilities and sheltered workshops and (6) rehabilitation centers.
- b. study of relationships among the various agencies serving the mentally ill such as the hospital, the half-way house, the State vocational rehabilitation and other public and voluntary agencies, the community, and the role of the mentally ill individual's family.
- c. experimentation with and evaluation of factors in the success of continued counseling of the mentally ill after they leave the hospital or transitional facilities.
- d. trial and study of the kinds of jobs and work situations that give the mentally ill the support and motivation needed to sustain rehabilitation.

-- Research and demonstration and the job of putting research-found knowledge to work by disseminating and applying research findings should be supported during the next ten years on the level of 20 percent of the total research and demonstration outlay each year, with the idea that this is a special emphasis level during this period. The rise should start with a level of support at 15% in 1965, reaching the level of 20% by 1970 and remaining at that level for a period of years.

Other Recommendations

A more thorough prospectus for OVR-supported research and demonstration efforts in psychiatric rehabilitation which should be stepped up or initiated is listed here in priority order within each of three major fields. Here vocational rehabilitation will be acting as a working partner with the hospital, for example, in the total effort to rehabilitate the mentally ill.

1. OVR-supported research and demonstration projects in the field of the family contribution to rehabilitating the mentally ill.

- Procedures working with social services to involve the family in treatment and rehabilitation of the mentally ill individual, during his hospital stay, during transition to community life, and during the post-transitional period, to prevent recurrence.
- Factors in family social structure and personality composition that help or hinder the patient in achieving successful adjustment.

2. OVR-supported projects in the field of the community contribution to rehabilitating the mentally ill.

- Setting up and evaluating various types of half-way houses such as those which provide psychiatric treatment and an activity program, those which do not provide such services, those in rural communities, etc. Study of the relations between hospital, half-way house, vocational rehabilitation and other agencies, the patient's family and the community.

- Setting up and evaluating day care and social centers, work adjustment centers, and sheltered workshops. Try-out of methods of integrating ex-mental patients with other disabled individuals and with other members of the community.

- Experimentation with different arrangements for and evaluation of the factors in the successful counseling of ex-patients after they leave hospital and transitional facilities.

- Experimentation with methods of developing and coordinating community resources so that the patient receives maximal assistance at all stages of rehabilitation.

- Determination of methods for involving community members in all phases of rehabilitation such as hospital activity, placement of patients about to be discharged, activities in half-way houses, day care and social centers, sheltered workshops, etc. Determination of methods for optimal use of such groups and volunteers, employers committees, associations of ex-patients, and citizens groups and committees.

3. OVR-supported research and demonstration projects in the field of the hospital's contribution to rehabilitating the mentally ill.

- Increase different kinds of in-hospital vocational programs such as sheltered workshop activities, employment of patients in or outside hospitals, vocational training, etc.

- Evaluation of "deinstitutionalization" during rehabilitation, i.e., allowing more privacy, freedom to go and come, entertain friends, etc.

- Therapeutic role of hospital staff such as psychiatrist, psychologist, vocational counselor, nurse, occupational therapist, social worker, rehabilitation counselor, attendant, other patients, and coordination of these roles in the rehabilitation process, e.g., involving psychiatrists in decisions regarding placement.

- Development and evaluation of group therapy or milieu therapy methods. Employing the hospital community to best advantage to give emotional support to patients during rehabilitation.

- Development of methods of appraising the rehabilitation potential of patients and of predicting post-hospital vocational adjustment.

OVR should continue to support projects for research and demonstration in the problems of rehabilitating groups whose mental illness is associated with such social problems as alcoholism.

OVR should consider the development of coordinated research programs in which, given a substantial area for research investigation, a grant is made to one institution which in turn subcontracts to or coordinates the research of other institutions. In organizing such an arrangement, consideration should also be given to making the summary and dissemination of research findings an integral contract responsibility of the coordinating institution.

OVR should intensify the steps it is taking to disseminate project results. These steps should include various conferences to bring together staff conducting research projects in psychiatric rehabilitation, those who are conducting demonstration projects in this field, and those who are conducting one of the demonstration series based on a prototype project. Such conferences should be held every two or three years to keep professional staff up-to-date.

OVR, in cooperation with the National Institute of Mental Health, should support the application of knowledge gained from research and demonstration projects through special efforts to bring results to service-providing programs such as the State agencies, mental hospitals, and community mental health clinics as well as to physician and employer groups.

D. Strengthening the State-Federal Vocational Rehabilitation Program

The State-Federal vocational rehabilitation programs - the core of the total public rehabilitation program - should be encouraged and aided in their efforts to:

- rehabilitate increasingly greater numbers of the mentally ill and increasing proportions of the mentally ill among the total number rehabilitated, and
- build and coordinate their programs of services for the mentally ill in the setting of the total public and voluntary service picture.

These recommendations assume the continuous strengthening of the State agency programs for rehabilitating the mentally ill that are already underway. These are designs for special emphasis measures to enable State agencies to meet their responsibilities for improving the programs of services for the mentally ill and for bringing services available to this group into better balance compared with services for other disability groups.

Nearly all these recommendations call for action on the parts of both the State vocational rehabilitation agencies and the OVR.

About the most effective way for a State agency to start a special administrative focus on psychiatric rehabilitation will be to

develop, with consultation from OVR central and regional office staff, a working plan extending over a five or ten year period. A working plan for a State should be carefully suited to the State's resources for serving the mentally ill. It should include a policy statement to guide staff action and agreements for cooperative working arrangements with other State agencies like the State mental health authority and the State mental hospitals.

-- OVR should furnish all possible support to State vocational rehabilitation agencies in their efforts to build (a) specialized staff and supervisory competencies in psychiatric rehabilitation and (b) general staff competence in psychiatric rehabilitation, mainly through full use of:

- special Federal support under premium matching rates up to 90 percent to finance in the State vocational rehabilitation agencies, specialist staff in psychiatric rehabilitation for a maximum of three to five years, under section 4 (a)(1) or possibly under a revised version of section 3. This could include staff such as (1) one or more State office specialists in planning and organizing special efforts to rehabilitate the mentally ill, (2) district and local office specialists, and (3) staff to provide ample, continuing psychiatric consultation to counselors, such as a psychiatrist, a psychiatric social worker, a psychologist, or a social worker with competency in psychotherapeutic counseling. This could also include, for example, a trial arrangement for using psychiatrists in a local community on a part-time fee basis, in a consulting rather than a direct treatment capacity.
- long and short-term training, in-service training, internships in selected mental institutions and other settings, educational leave with and without pay.

-- OVR should furnish all possible support and aid to State vocational rehabilitation agencies to help them build up their programs of services for the mentally ill and to help them build up the facilities for serving this group of the disabled. OVR should actively encourage State vocational rehabilitation agencies to participate in and to conduct research and demonstration projects dealing with the mentally ill and their rehabilitation. OVR should also encourage the involvement of these State agencies in integrated or cooperative programs with other State and voluntary agencies, in a variety of ways, including expansion-type grant projects.

-- With OVR encouragement and assistance, State vocational rehabilitation agencies should undertake new administrative operations and measures to improve services for the mentally ill in these areas:

- early identification of the mentally ill who can profit from vocational rehabilitation services such as
 - (1) working with school officials to arrange early referral and services for secondary school students who are mentally ill, and

(2) stationing counselors in in-hospital rehabilitation units and in out-patient clinics.

- work with social service agencies to counsel the families of the mentally ill clients.
- specialized placement for the mentally ill, with consideration given to special living arrangements.
- follow-up services for at least six months to assure that the mentally ill person maintains his gains from rehabilitation. This should include providing on-the-spot counseling service to the employer and the mentally ill client-employee.
- developing facilities for direct provision of services as in a State-agency-operated rehabilitation center, half-way house or workshop.
- developing arrangements to tie in with community facilities which serve the mentally ill, both for those who are hospitalized and for those who are either ex-patients or out-patients, including the small psychiatric unit in a general hospital, the State mental hospital, rehabilitation facilities, workshops, and mental health clinics. Through assignment of counselors or its influence as purchaser of services, the State agency should exercise its leadership role to build psychiatric rehabilitation into a variety of settings.
- developing - on the State agency's own part and in active cooperation with other agencies - programs to build understanding about what vocational rehabilitation has to offer in the total rehabilitation on the mentally ill person. This should include working closely with:
 - State public health, mental health and Hill-Burton authorities
 - Governor's Committee for Employment of the Handicapped
 - State Employment Service
 - Veterans Administration hospitals and out-patient clinics
 - medical societies
 - employer groups, particularly industrial health and placement staff
 - mental health associations
 - local mental health clinics
 - community groups
 - law enforcement officials
- developing a State agency-conducted research and demonstration project activity to help the State agency try out and evaluate different approaches to improving its services to the mentally ill. This activity should be under the expert leadership of a specialist and should make full use of the various project forms, such as research, demonstration, expansion, extension and improvement as well as basic support program funds.

- developing special assignments of staff with skills in psychiatric rehabilitation to work exclusively with the mentally ill or nearly so, or, for example, staff assigned in populous areas to work exclusively with an ex-patient group.

E. Educating the General and the Special Publics

To support and to prepare the way for more, successful rehabilitations of the mentally ill, the OVR should provide leadership and financial help - on larger scale than in the past - to efforts of Federal, State, and local public and voluntary groups to achieve greater understanding about mental illness and about the rehabilitation potential of the mentally ill.

For the OVR and for the State vocational rehabilitation agencies, particularly, this educational effort includes working with:

- other Federal and State agencies such as the President's Committee on Employment of the Handicapped and the Governor's Committee in each State, the National Institute of Mental Health, the State Employment Services, and the Veterans Administration.
- National, State and local mental health associations
- the Conference of Rehabilitation Centers, and the Association of Sheltered Workshops
- employer groups including industrial health and personnel staff
- labor groups
- national organizations for men and for women, and church groups

Recommendations of First Priority

- OVR should make a grant to the National Mental Health Association to plan and carry out a 5-year program for public education on rehabilitation of the mentally ill. The planning should be for:
 - developing a full-scale public education and information program in cooperation with the President's Committee, the National Institute of Mental Health, and the Employment Service. One special item should be material for employers about mental illness and rehabilitation.
 - developing a program for selecting and using volunteers in various settings for rehabilitating the mentally ill.

-- OVR, in cooperation with the NIMH and others, should support the making of two films on rehabilitating the mentally ill, one for the general public and later, another for physicians. The Mental Health Film Board should make these films.

- (1) contract for additional "Plays for Living", addressed to the rehabilitation of the mentally ill
- (2) update "Psychiatric Information for the Rehabilitation Worker"
- (3) issue for general use one or more booklets on rehabilitation and job placement for those who have been mentally ill

-- OVR should take the initiative in forming a joint working group of the OVR, the President's Committee, the Veterans Administration, the NIMH, and the U.S. Employment Service, to concern itself with

- (1) special employer councils to help in placement of the mentally ill who are rehabilitated, and
- (2) emphasis on the mentally ill at regional meetings of the President's Committee, and of Governors' Committees.

F. Legislative Proposals

Certain legislative action, with marked increase in appropriations, would contribute greatly to progress in rehabilitation at significantly accelerated rates and to strengthening the program in the nation.

The authority in the current Vocational Rehabilitation Act is broad enough to encompass much of what this report projects as necessary to the rehabilitation of far more of the mentally ill than we have yet achieved, or will achieve if our progress remains at the rates of recent years.

Recommendation of First Priority

However, one major change - applicable across the board to rehabilitation of all the disability groups, physical and mental - will be needed to enable the program to make realities of these projections.

-- Re-enactment of the type of expansion grant authority in section 4 (a)(2) of the Vocational Rehabilitation Act for a 10-year period for grants to public and voluntary nonprofit agencies would give much needed impetus to community facilities and to programs of services for the mentally ill. Grants for projects of three or five years duration would be used to pay part of the costs of construction or alteration of buildings and for initial staff, initial equipment and operating costs for up to three years, in a wide spectrum of community facilities and programs to rehabilitate the mentally ill. These project grants,

averaging \$15,000-\$20,000, could be made in larger number each year, beginning with 50 in the field of mental illness in 1964 - the first full year of operation - and increasing to 150 in 1966, to remain at that level through 1970.

Another desirable change would be to raise to 3 years the limitation on training support [section 4 (a)(1)]. This would encourage post graduate courses of study in professional fields where such training is taking on increasing importance. This change would allow training up to 3 years in all professional fields which are now limited to two years except for physical medicine and rehabilitation.

G. Conclusion

The outlook is that, with these recommended actions for an intensified program for rehabilitating the mentally ill, in 1970 we will be rehabilitating 16,000 mentally ill persons - as a reasonable prospect - or 20,000 as an optimistic prospect. The estimate of 16,000 amounts to 8 percent of the total goal for 1970. The estimate of 20,000 amounts to 10 percent of the total goal for that year, and assumes full-scale expansion in hospital and out-patient service facilities as well as in vocational rehabilitation.

Quite as important is the expectation that if the vocational rehabilitation program can proceed on these recommended actions, we will by 1970 have built into the rehabilitation program strong elements for providing rehabilitation services to the mentally ill, and we will have brought the rehabilitation of this group into good balance as compared with services for other disability groups in quality and quantity of services.

Appendix: Background Information on the Mentally
Ill and Their Rehabilitation

HIGHLIGHTSDATA ON THE MENTALLY ILL AND THEIR REHABILITATIONPrevalence

- 17 million people in the country have a well-defined mental or emotional disorder - as a rough estimate -
 - 1 out of 5 cases diagnosed as mental disorder well adjusted enough to maintain themselves independently in the community

Hospitalized Patients

- 542,000 patients were in our 277 public hospitals for the mentally ill on December 31, 1959 - a decrease of 17,000 since 1956.
 - about 175,000 patients were released from these hospitals in 1959.
 - upward trends in
 - total admissions since 1940's, for new admissions and readmissions, and
 - net releases to communities from these hospitals
- about 15% of the patients leaving the hospital need and could use vocational rehabilitation services

Outpatient Psychiatric Clinics

- 1429 outpatient psychiatric clinics, public and private, in 1959
 - one or more in each state
- less than 1 clinic per each 100,000 population

OASI Disability Applicants

- about 11% of 184,500 allowances by BOASI in 1958 had primary diagnosis of a mental, psychoneurotic, or personality disorder
 - including about 4% mentally retarded
- 10% of the 204,000 denials by BOASI had this primary diagnosis - again including the mentally retarded

Mentally Ill Persons Rehabilitated by State VR AgenciesNational

- number of mentally ill rehabilitated by State agencies has more than quadrupled in the last 17 years - from under 1,400 in Fiscal 1945 to almost 6,400 in 1961
 - proportion of all rehabilitants with mental illness has risen from 3.2% in 1945 to 6.9% in 1961
- in 1961 the 6,400 mentally ill persons rehabilitated included
 - 3,000 with psychoses
 - 2,100 with psychoneuroses
 - almost 1,300 with personality, character and behavior disorders
- principal types of disability in this group in 1960
 - 34% - schizophrenic disorders
 - 14% - anxiety reactions
 - 11% - pathological personality

Variations Among States

- 4,600 mentally ill persons rehabilitated in 1959 were equivalent to 2.6 rehabilitants per 100,000 population

<u>Top States</u>	Delaware	15.9 rehabilitants per 100,000
	West Virginia	14.1
	Vermont	13.2
	Arkansas	11.0
	Rhode Island	9.4
	Utah	6.9
	Washington, D. C.	6.4
	Virgin Islands	6.2

Outlook

- if increases in rehabilitation of the mentally ill continue at the same rate as in the past several years, we would see the rehabilitation of

7,350 mentally ill in 1962 -- 6.2% of the total goal of 100,000

9,700 mentally ill in 1966 -- 6.5% of the total proposed goal of 150,000

13,600 mentally ill in 1970 -- 6.8% of the total proposed goal of 200,000

- under these proposals for intensified program, we could see as a reasonable expectation for rehabilitation of

10,500 mentally ill in 1966 -- 7% of the proposed goal of 150,000

16,000 mentally ill in 1970 -- 8% of the proposed goal of 200,000

- under these proposals, assuming full-scale expansion in hospital and out-patient service facilities as well as in vocational rehabilitation, we could see as an optimistic expectation the rehabilitation of

12,000 mentally ill in 1966 -- 8% of the proposed goal of 150,000

20,000 mentally ill in 1970 -- 10% of the proposed goal of 200,000

SOME BACKGROUND STATISTICAL INFORMATION ON
THE MENTALLY AND EMOTIONALLY ILL a/

1. Prevalence:

It is estimated that 10 percent of the non-institutional population or some 17 million people in this country have a well-defined mental or emotional disorder.

This estimate is based primarily on the 1952-1953 survey in Baltimore, Maryland. Findings from this survey and follow-up clinical evaluations of the survey population indicate that more than 10 percent of the non-institutional population in the study were diagnosed as having a well-defined mental disorder. Half of the cases were psychoneuroses, one-third were psychoneuroses with somatic manifestations. The remainder of the cases included psychoses, mental deficiency, alcoholism, and other mental disorders. These diagnoses were made by the examining internists and reviewed by a psychiatrist. Questionable diagnoses were excluded as were those whose mental disorders were no longer present.^{b/} If the group with mental deficiency were omitted, the prevalence rate for mental disorders would be roughly 10 percent.

Studies in other areas of the country tend to confirm the findings from the Baltimore survey.

The Baltimore survey indicated that one out of 5 cases diagnosed as mental disorder were well adjusted to such a degree that there was no medical reason to change the employment or life situation.

The prevalence of mental disorders among the non-institutional population in the Baltimore study was highest among persons aged 15 to 34 (148 per 1,000), and declined a little with increasing age to 115 per 1,000 for persons 65 and over. The rate was lowest for those under 15 (34 per 1,000).

The following sections on mental hospital and clinic population and the findings among the OASI disability applicants are further indications of the size of this problem and the extent of need for service.

a/ Persons with psychoses, psychoneuroses, and those with personality, character, and behavior disorders.

b/ Commission on Chronic Illness, Chronic Illness in a Large City, Vol. IV, pp 95-100. Commonwealth Fund Book-Harvard University Press 1957.

2. Hospitalized Patients:

Reports from the National Institute of Mental Health indicate that the number of patients in the 277 public hospitals for the mentally ill stood at 542,000 on December 31, 1959. This is a decrease of 17,000 since 1956.

There has been an upward trend in total admissions--in both new admissions and in re-admissions--since the mid-1940's. Between 1959 and 1960 new admissions leveled off but readmissions continued to increase.

Net releases to the community from these hospitals have also been increasing since the mid-1940's. (Net releases are placements in extramural care plus direct discharge less the number of returns from extramural care.)

Considerable variation may be seen among the states in the ratio of hospitalized patients to population. In 1959, there were 302 patients in mental hospitals per each 100,000 population in the United States. (See Table A.)

The areas with the highest ratios were: The District of Columbia (831) New York (562), New Hampshire (435), Massachusetts (433), Rhode Island (391), Delaware (386), and Wisconsin (371).

Those with the lowest ratios were: New Mexico (102), Utah (128), Arizona (135), Idaho (146), Iowa (160), Texas (167), and Kansas (177).

3. Outpatient Psychiatric Clinics:

In 1959 there were 1,429 outpatient psychiatric clinics (public and private) in the United States--one or more in each of the States and Territories with the exception of Guam. (See Table A.)

The number per State ranged from 1 each in the Virgin Islands, North Dakota, and Idaho to 303 in New York.

For the entire United States, in 1959, the 1,429 clinics represented less than one clinic per each 100,000 population.

Those States with proportionately the largest number of such facilities were: New Hampshire (22 clinics--a ratio of 3.7 per 100,000 population), Alaska (7 clinics, a ratio of 3.7), Virgin Islands (1 clinic, a ratio of 3.1), the District of Columbia (17 clinics, a ratio of 2.0), Wyoming (6 clinics, a ratio of 1.9), and New York (303 clinics, a ratio of 1.8).

3. Outpatient Psychiatric Clinics: - continued

There were 7 States where this ratio of clinics to population was 0.3 or less--Puerto Rico (2 clinics, ratio of 0.1), Idaho (1 clinic, ratio of 0.2), North Dakota (1 clinic, ratio of 0.2), Arkansas (3 clinics, ratio of 0.2), Oklahoma (5 clinics, ratio of 0.2), New Mexico (2 clinics, ratio of 0.2), and Mississippi (5 clinics, ratio of 0.2).

Since these clinics vary considerably in size, data on number of patients served give a better idea of the extent to which people are utilizing these facilities.

In 1959, reports from 1,073 (of the 1,429) outpatient psychiatric clinics indicated a total of 383,000 served. This is equivalent to 213 patients per 100,000 population.

New York leads the States with 634 served in such clinics per 100,000 population. Following closely are the District of Columbia (590), Connecticut (525), Delaware (466), and Maryland (346).

Ratios were lowest in New Mexico (7), Puerto Rico (40), Arkansas (43), Idaho (49), New Jersey (49), Mississippi (52), Oklahoma (54), and North Dakota (54).

4. OASI Disability Applicants:

Some indication of the extent of incapacitating mental or emotional illness among OASI disability applicants is evident from data on persons allowed and denied OASI disability benefits in 1958.

Of the 184,500 allowances made by BOASI in worker cases (applicants for freeze and cash benefits) in 1958, about 11 percent had a primary diagnosis of a mental, psychoneurotic, or personality disorder. This is including about 4% who were mentally retarded.

For the 204,110 denials made by BOASI in worker cases, 10 percent were reported to have primary diagnoses of mental, psychoneurotic, or personality disorders (including the mentally retarded).

Among the childhood cases, 21,300 were allowed in 1958. About 53 percent of these were persons with mental or emotional illness or mental retardation. Some 49 percent were mentally retarded and 4 percent were mentally or emotionally ill.

The 5,500 denials that year among childhood cases included 37 percent with mental or emotional illness or mental retardation.

5. Rehabilitants of the State Vocational Rehabilitation Agencies:

The number of rehabilitants of the State vocational rehabilitation agencies whose major disability was a mental or emotional illness has more than trebled in the past 15 years. In fiscal year 1945, less than 1,400 were rehabilitated compared with nearly 4,600 in fiscal year 1959. (See Table N-82).

The proportion of all rehabilitants with a major disability of mental or emotional illness has steadily increased from 3.2% in fiscal year 1945 to 5.7% in fiscal year 1959.

--Types of disabilities:

The 4,600 of these rehabilitants in fiscal year 1959 included 2,000 with psychoses, 1,600 with psychoneuroses and nearly 1,000 with personality, character, and behavior disorders.

The principal types of disability among these 4,600 rehabilitants in fiscal year 1959 were: schizophrenic disorders (31%), anxiety reactions (12%), and pathological personality (11%).

--Age:

The rehabilitants among the mentally or emotionally ill are only slightly younger than the remainder of the rehabilitants. (see Table N-83).

--Secondary disabilities:

Secondary disabilities were reported for nearly 1,000 or about 21 percent of the 4,600 mentally or emotionally ill who were rehabilitated in fiscal year 1959. These secondary disabilities included 5 deaf, 75 mentally retarded, and 900 with other types of conditions which included nearly all other types of disabilities other than blindness.

Two groups of the severely disabled--the deaf and the blind--included about 1 percent with a secondary disability of mental or emotional illness. (36 of the 4,200 blind rehabilitated in fiscal year 1959 had such a secondary disability and 18 of the 1,600 deaf rehabilitants.)

5. Rehabilitants of the State Vocational Rehabilitation

Agencies: - continued

--Variations Among Regions and States:

The 4,600 mentally or emotionally ill rehabilitated in fiscal year 1959 were equivalent to 2.6 rehabilitants per 100,000 population. These rates ranged from 4.2 in Region VIII (Denver) and 4.1 in Region I (Boston) to 1.7 in Region V (Chicago) and 1.6 in Region IX (San Francisco). (See Tables S-56, S-40, S-41, and S-55.)

Those States in which 6 or more such persons were rehabilitated per each 100,000 population included: Delaware (15.9), West Virginia (14.1), Vermont (13.2), Arkansas (11.0), Rhode Island (9.4), Utah (6.9), District of Columbia (6.4), and the Virgin Islands (6.2).

Among all agencies in fiscal year 1959, 6 percent of the rehabilitants were persons whose major disability was a mental or emotional illness. By region this proportion ranged from 11 percent in Region I to 3 percent in Region IV.

States in which 12 percent or more of the rehabilitants in fiscal year 1959 were those whose major disability was a mental or emotional illness included: Vermont (21%), the District of Columbia (17%), Connecticut (14%), Delaware (14%), Utah (14%), Arizona (13%), and Rhode Island (12%).

6. Rehabilitants in Relation to Mental Hospital Population and Patients Served in Psychiatric Clinics:

A substantial number of persons whose major disability had been a mental or emotional illness and who came to the State agencies for service would have been mental hospital or clinic patients. Hence, a comparison of the number of rehabilitants whose disability had been mental illness with the size of the mental hospital and clinic populations in the various States may give some idea of the extent to which the rehabilitation needs of these patients are being met. This rough comparison does not take into account the extent to which the rehabilitation needs of these people are being met through the hospitals, clinics or other agencies in the various States.

To make such a comparison, all three groups will need to be expressed as ratios based on the respective total State populations. For all agencies, these ratios are: 2.6 rehabilitants in FY 1959 (disability, mental illness) per 100,000 population; 302 patients in mental hospitals at the end of 1959 per 100,000 population; and 213 patients served in outpatient psychiatric clinics in 1959 per 100,000 population. (See Table A.)

6. Rehabilitants in Relation to Mental Hospital Population and Patients Served in Psychiatric Clinics: - continued

A rough indication of those areas in which there appears to be a need for expanding services to the mentally ill even under the present program might be found where the rehabilitation ratio is substantially lower than the ratios of patients in mental hospitals and clinics. One might select as the high ratios those of 3.6 or more rehabilitants, 390 or more hospitalized patients, and 260 or more clinic patients; while abnormally low ratios could be those of 1.7 or fewer rehabilitants, 250 or fewer hospitalized patients, and 150 or fewer clinic patients served.

Using these rough guides, Regions III and VIII have relatively high rehabilitation ratios but low to average clinic and hospital ratios, hence their record, as of now, would appear to be better than average, in relation to meeting the known need (size of clinic and hospital population). However, Regions III and VIII, except for Maryland and the District of Columbia, have relatively limited resources--other than the State rehabilitation agencies--which could contribute to the rehabilitation of the mentally ill. Therefore, the vocational rehabilitation agencies have relatively greater responsibility for this work and could be expected to show a higher ratio of rehabilitations.

On the other hand, Region II with high hospital and clinic ratios shows only a moderately high rehabilitation ratio. Region V has average hospital and clinic ratios but a low ratio of rehabilitants. Both regions appear to be in need of expanding their rehabilitation services to the mentally ill. But both Regions II and V, particularly New York, Pennsylvania, Illinois and Michigan, have many more resources, other than the State rehabilitation agencies, at their disposal for meeting the needs of these people.

Individual States in which the rehabilitation ratios are substantially below the ratios for mental hospital and clinic patients are: Massachusetts, New Hampshire, New Jersey, New York, Maryland, Illinois, Michigan, Ohio, Missouri, Alaska, and California. Except for New Hampshire and Alaska, these are States with many resources in addition to the State vocational rehabilitation agencies. Alaska having no mental hospital has been using Morningside Hospital in Portland, Oregon.

7. Research and Demonstration Projects Serving and Rehabilitating the Mentally and Emotionally Ill:

In fiscal year 1960, 21 of the 138 research and demonstration projects providing service to disabled persons were serving the mentally or emotionally ill. (See attached Table B.) There were in addition, seven research and demonstration projects concerned with rehabilitation of the mentally or emotionally ill but not designed to provide service to those people.

7. Research and Demonstration Projects Serving and Rehabilitating the Mentally and Emotionally Ill: - continued

These 21 projects reported serving 2,600 disabled persons during the fiscal year including 780 who were clients of the State vocational rehabilitation agencies and 325 other persons.

8. The Future:

If the proportion of rehabilitants who were mentally ill continues to increase at the same rate as in the past three to five years, the State vocational rehabilitation agencies could be expected to increase the number of these persons from 4,600 in fiscal year 1959 to 6,600 in fiscal year 1962 to 9,700 in fiscal year 1966. By 1970, assuming a 200,000 rehabilitation goal, about 13,600 would be expected to be from the ranks of the mentally ill. (See Table C.) The total rehabilitation goals used are the preliminary budget estimates of 107,000 in 1962, 120,000 in 1963, and 150,000 in 1966. The 1970 goal is that proposed under the previous administration of 200,000.

With the intensified program proposed by the Task Force, a substantial increase in both the number and proportion of rehabilitants among the mentally ill would be expected. Two sets of estimates are suggested here--Estimate I, which assumes a moderate speed-up in the program, and Estimate II, which assumes a more intensive push along with substantial improvement in hospital and clinic services.

Under Estimate I, the State agencies would reach a level of 10,500 rehabilitants among the mentally ill by fiscal year 1966 and a level of 16,000 by 1970. These correspond to 7 percent of all rehabilitants in 1966 and 8 percent in 1970.

Under Estimate II, the State agencies would reach a level of 12,000 in 1966 and 20,000 in 1970. This proportion of all rehabilitants would be 8 percent in 1966 and 10 percent in 1970.

No attempt has been made to estimate the additional number of rehabilitants that might be expected through research and demonstration projects, through expansion projects or through extension and improvement projects under either the present or the intensified rehabilitation program for the mentally ill except as they are reflected in Estimates I and II. The numbers that could be anticipated would be small particularly from the research area because of the type of emphasis proposed.

The projected number of rehabilitations among the mentally ill for 1970 appears realistic if the recommendations of the Joint Commission are implemented within the next few years. There should then be:

8. The Future: - continued

1. Greatly increased resources for out-patient treatment so that hospitalization will not be necessary in many instances and an acute breakdown necessitating leaving the job may be prevented.
2. Hospitals will offer much more intensive programs of treatment and rehabilitation, employing their own vocational rehabilitation personnel.
3. Many more rehabilitation resources will be available in the community.
4. Increased enlightenment of the public, resulting in a much more receptive attitude toward mental illness.

Thus the vocational rehabilitation agency will be one of many offering services to the mentally ill or emotionally disturbed.

Table A.--Rehabilitants of the State vocational rehabilitation agencies in fiscal year 1959 whose major disability was mental or emotional illness; and patients in public mental hospitals and those served in out-patient psychiatric clinics in 1959: the number and the number per 100,000 population by Region and State (Cont'd)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
State	Former mentally ill: persons rehabilitated in fiscal year 1959 a/	Number of out-patient psychiatric clinics in 1959	Out-patient psychiatric clinics per 100,000 population:	Patients under care in out-patient psychiatric clinics in 1959	Patients under care in out-patient psychiatric clinics in 1959	Patients released from mental hospitals at the end of 1959	Patients in public mental hospitals at the end of 1959	Patients in public mental hospitals at the end of 1959
Total Reg. IV.	469	2.4	0.38	28,918	145	15,973	48,594	244
Ala.	52	1.6	0.41	2,315	73	2,337	7,400	232
Fla.	146	3.1	0.61	13,015	273	1,971	9,164	192
Ga.	169	4.4	0.29	3,985	104	2,811	11,922	311
Miss.	14	0.6	0.23	1,137	52	2,883	5,216	239
S. C.	26	1.1	0.25	3,107	129	1,884	6,604	273
Tenn.	62	1.8	0.31	5,359	153	4,087	8,288	237
Total Reg. V..	618	1.7	0.65	74,283	203	34,499	112,106	307
Ill.	246	2.4	0.82	23,106	226	11,330	35,835	351
Ind.	72	1.6	0.43	6,319	136	3,369	10,943	236
Mich.	114	1.4	0.65	14,322	180	4,447	21,762	273
Ohio.....	86	0.9	0.63	23,303	240	10,228	28,670	296
Wis.	100	2.5	0.52	7,233	180	5,125	14,896	371
Total Reg. VI.	363	2.4	0.75	20,480	133	15,451	37,998	247
Iowa.....	102	3.6	0.57	4,050	144	3,338	4,488	160
Kans.	4	0.2	0.98	2,321	108	2,050	3,798	177
Minn.	100	2.9	0.47	5,853	172	4,063	10,648	313
Mo.	67	1.6	1.13	4,559	107	2,031	11,447	270
Nebr.	50	3.4	0.69	2,252	155	1,956	4,228	290
N. Dak.	27	4.2	0.16	345	54	1,274	1,695	264
S. Dak.	13	1.9	0.44	1,100	160	739	1,694	247

Continued

For footnote see end of table.

Table A.--Rehabilitants of the State vocational rehabilitation agencies in fiscal year 1959 whose major disability was mental or emotional illness; and patients in public mental hospitals and those served in out-patient psychiatric clinics in 1959: the number and the number per 100,000 population by Region and State (Cont'd)

State	(1)		(2)		(3)		(4)		(5)		(6)		(7)		(8)		(9)	
	Former mentally ill: persons rehabilitated in fiscal year 1959 a/	Number per 100,000 population	Number of out-patient psychiatric clinics in 1959	Out-patient psychiatric clinics per 100,000 population	Number of out-patient psychiatric clinics in 1959	Patients under care in out-patient psychiatric clinics in 1959	Patients under care in out-patient psychiatric clinics in 1959	Patients released in public mental hospitals from mental hospitals on December 31, 1959	Patients released in public mental hospitals from mental hospitals on December 31, 1959	Patients released in public mental hospitals from mental hospitals on December 31, 1959	Patients released in public mental hospitals from mental hospitals on December 31, 1959	Patients released in public mental hospitals from mental hospitals on December 31, 1959	Patients released in public mental hospitals from mental hospitals on December 31, 1959	Patients released in public mental hospitals from mental hospitals on December 31, 1959	Patients released in public mental hospitals from mental hospitals on December 31, 1959	Patients released in public mental hospitals from mental hospitals on December 31, 1959	Patients released in public mental hospitals from mental hospitals on December 31, 1959	Patients released in public mental hospitals from mental hospitals on December 31, 1959
Total Reg. VII	450	2.6	62	0.35	14,481	82	16,670	37,509	213									
Ark.	191	11.0	3	0.17	748	43	2,588	4,948	284									
La.	74	2.3	22	0.69	4,731	149	3,116	8,530	269									
N. Mex.	7	0.8	2	0.23	64	7	666	898	102									
Okla.	74	3.3	5	0.22	1,238	54	2,069	7,276	320									
Tex.	104	1.1	30	0.32	7,700	81	8,231	15,857	167									
Total Reg. VIII	176	4.2	33	0.78	4,508	107	3,855	10,362	245									
Colo.	84	5.0	17	1.01	1,545	92	1,338	5,943	353									
Idaho.	2	0.3	1	0.15	328	49	786	970	146									
Mont.	22	3.2	3	0.44	1,396	203	925	1,673	244									
Utah.	61	6.9	6	0.68	1,041	118	582	1,128	128									
Wyo.	7	2.2	6	1.88	198	62	223	648	203									
Total Reg. IX.	341	1.6	134	0.62	44,908	207	24,344	51,183	236									
Alaska.	3	1.6	7	3.66	555	291	--	--	--									
Ariz.	63	5.1	5	0.40	1,116	91	806	1,670	135									
Calif.	142	1.0	85	0.58	35,069	240	18,055	37,290	255									
Hawaii.	a/	a/	7	1.07	1,497	228	--	--	--									
Nev.	4	1.4	3	1.07	202	72	286	553	198									
Oreg.	46	2.6	15	0.85	2,035	115	3,018	4,993	283									
Wash.	83	2.9	12	0.43	4,434	157	2,179	6,677	237									
Guam.	0	0.0	--	--	--	--	--	--	--									

a/ Excludes data, which are not available, on persons disabled from mental or emotional illness who were among the 189 persons rehabilitated by the Hawaii general agency.

Sources of data are shown on the back of Table A.

Source of data on rehabilitants:
Closed Case Reports, Form R-9.

Source of mental hospital and clinic
data: NIMH--Mental Health Statis-
tics, Series MHB-H-5, dated Janu-
ary 1961; and NIMH "Data on Patients
of Outpatient Psychiatric Clinics in
the United States, 1959", dated
February 1961.

Prepared by
Office of Vocational Rehabilitation
Division of Statistics and Studies
June 1961

Table N-82.--State vocational rehabilitation agencies: Number ^{1/} of persons with mental or emotional illness as their major disability, rehabilitated in fiscal years ending June 30, 1945-1959

(1)	(2)	(3)	(4)	(5)	(6)
	: Number of rehabilitants		:	: Number disabled from	
Fiscal:	Total	:Disabled from mental illness:	:	: mental illness as	
year :		:Psychosis and	: Other ^{2/} :	: percent of total	
:		:psychoneurosis	:	:Psychosis and	: Other ^{2/}
:		:	:	:psychoneurosis	:
1945	41,925	1,285	71	3.0	0.2
1946	36,106	995	87	2.7	0.2
1947	43,880	1,238	108	2.8	0.2
1948	53,131	1,626	124	3.1	0.2
1949	58,020	1,832	148	3.2	0.3
1950	59,597	1,919	119	3.3	0.2
1951	66,193	2,260	147	3.5	0.2
1952	63,632	1,962	119	3.1	0.2
1953	61,308	1,938	145	3.3	0.2
1954	55,825	1,708	121	3.1	0.2
1955	57,981	1,793	248	3.1	0.4
1956	65,640	2,192	324	3.3	0.5
1957	70,940	2,796	373	4.0	0.5
1958	74,317	3,221	524	4.3	0.7
1959	80,739	3/3,663	3/929	3/4.5	3/1.2

^{1/} Data involve sampling, with expansion to approximate completeness. The fiscal year 1945 is the year ending June 30, 1945; and so on.

^{2/} Personality, character, and behavior disorders. In fiscal years 1945-1950, these are rehabilitants whose major disability was classified as psychopathic personality and migraine. (The number disabled by migraine has not exceeded 30 per year since 1950.) In fiscal years 1951-1958 these data are limited to psychopathic personality. In fiscal year 1959, all types of personality, character, and behavior disorders are included--mental deficiency is excluded.

^{3/} Excludes data, which are not available, on any persons disabled from mental illness who were among the 189 persons rehabilitated by the Hawaii general agency.

Table N-83.--State vocational rehabilitation agencies: Number of persons with mental or emotional illness as their major disability, rehabilitated in fiscal year ending June 30, 1959; grouped by age at acceptance for vocational rehabilitation services

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Age	Rehabilitants				Type of mental or emotional illness			
at	with mental or	Psychosis						
acceptance:	emotional illness <u>a/</u> :							
in years	Number :	Percentage:	Number :	Percentage:	Number :	Percentage:	Number :	Percentage
All ages	4,592	100	2,028	100	1,635	100	929	100
15-24	1,199	26	455	22	401	25	343	37
25-44	2,515	55	1,145	57	944	57	426	46
45-64	873	19	423	21	290	18	160	17
65 & over	5	*	5	*	0	0	0	0

a/ Data for some States involve sampling with expansion to 100% completeness. Secondary disabling conditions, other than mental or emotional illness, were reported for 982 or 21% of these 4,592 rehabilitants. Of these 982, none were blind, 75 were also mentally retarded, and 907 had some other secondary disability.

* Less than half of 1%.

Source: Closed Case Reports, Form R-9.

Prepared by: Division of Statistics and Studies
Office of Vocational Rehabilitation
U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Washington 25, D. C.
May 1961

Table S-56.---State vocational rehabilitation agencies: Number of persons with mental or emotional illness a/ as their major disability, rehabilitated in fiscal year ending June 30, 1959; grouped by State

(1)	(2)	(3)	(4)	(5)	(6)
D/HEW region, regional headquarters, and State	: Total : population:	Total number :Rehabilitants with a mental or emotional illness b/	Number : Percent of total : Number per 100,000	: rehabilitants :	population
: (000) :rehabilitated:					
Total U. S., including territories	179,454	80,739	4,592	6	2.6
Region I (Boston).....	10,154	3,863	413	11	4.1
Connecticut.....	2,415	978	139	14	5.8
Maine.....	949	379	38	10	4.0
Massachusetts.....	4,951	1,420	96	7	1.9
New Hampshire.....	592	180	9	5	1.5
Rhode Island.....	875	677	82	12	9.4
Vermont.....	372	229	49	21	13.2
Region II (New York City) .	34,202	13,655	1,042	8	3.0
Delaware.....	454	518	72	14	15.9
New Jersey.....	5,930	1,516	58	4	1.0
New York.....	16,495	5,504	477	9	2.9
Pennsylvania.....	11,323	6,117	435	7	3.8
Region III (Charlottesville, Virginia)...	19,850	14,497	720	5	3.6
District of Columbia....	840	324	54	17	6.4
Kentucky.....	3,125	1,240	30	2	1.0
Maryland.....	3,031	1,342	90	7	3.0
North Carolina.....	4,530	4,766	100	2	2.2
Puerto Rico.....	2,335	970	18	2	0.8
Virginia.....	3,992	3,167	148	5	3.7
Virgin. Islands.....	32	23	2	9	6.2
West Virginia.....	1,965	2,665	278	10	14.1

For footnotes see end of table.

Continued

Table S-56, continued

(1) D/HEW region, regional headquarters, and State	(2) : Total : population: : (000)	(3) :Total number :of persons : :rehabilitated:	(4) :Rehabilitants with a mental or emotional illness b/ : Number : Percent of total : Number per 100,000	(5) : rehabilitants :	(6) : population
Region IV (Atlanta).....	19,895	16,703	469	3	2.4
Alabama.....	3,193	2,363	52	2	1.6
Florida.....	4,761	3,031	146	5	3.1
Georgia.....	3,838	5,628	169	3	4.4
Mississippi.....	2,185	1,538	14	1	0.6
South Carolina.....	2,417	1,596	26	2	1.1
Tennessee.....	3,501	2,547	62	2	1.8
Region V (Chicago).....	36,513	10,733	618	6	1.7
Illinois.....	10,205	3,793	246	6	2.4
Indiana.....	4,638	1,232	72	6	1.6
Michigan.....	7,960	2,727	114	4	1.4
Ohio.....	9,700	1,638	86	5	0.9
Wisconsin.....	4,010	1,343	100	7	2.5
Region VI (Kansas City)...	15,376	6,354	363	6	2.4
Iowa.....	2,809	1,202	102	8	3.6
Kansas.....	2,140	970	4	*	0.2
Minnesota.....	3,399	1,255	100	8	2.9
Missouri.....	4,243	1,674	67	4	1.6
Nebraska.....	1,456	685	50	7	3.4
North Dakota.....	642	309	27	9	4.2
South Dakota.....	687	259	13	5	1.9
Region VII (Dallas).....	17,578	8,488	450	5	2.6
Arkansas.....	1,744	2,169	191	9	11.0
Louisiana.....	3,166	1,881	74	4	2.3
New Mexico.....	879	305	7	2	0.8
Oklahoma.....	2,276	1,560	74	5	3.3
Texas.....	9,513	2,573	104	4	1.1

For footnotes see end of table.

Continued

Table S-56, continued

(1) D/HEW region, regional headquarters, and State	(2) : Total : population: : (000) : rehabilitated:	(3) : Total number : Rehabilitants with a mental or emotional illness b/ : of persons : Number : Percent of total : Number per 100,000 : rehabilitated: : rehabilitants : population	(4)	(5)	(6)
Region VIII (Denver).....	4,232	2,144	176	8	4.2
Colorado.....	1,682	856	84	10	5.0
Idaho.....	664	269	2	1	0.3
Montana.....	687	423	22	5	3.2
Utah.....	880	432	61	14	6.9
Wyoming.....	319	164	7	4	2.2
Region IX (San Francisco).....	21,654	4,302	341	8	1.6
Alaska.....	191	45	3	7	1.6
Arizona.....	1,233	484	63	13	5.1
California.....	14,639	1,790	142	8	1.0
Guam c/.....	66	0	0	0	0.0
Hawaii.....	656	205	b/	b/	b/
Nevada.....	280	100	4	4	1.4
Oregon.....	1,766	668	46	7	2.6
Washington.....	2,823	1,010	83	8	2.9

a/ Defined here to include psychoses, psychoneuroses, and personality, character, and behavior disorders. (The latter three groups include pathological personality, immature personality, alcoholism other than alcoholic psychoses, drug addiction other than that with psychoses, primary childhood behavior disorders, and other such conditions. They will exclude mental deficiency.)

b/ Excludes data, which are not available, on persons disabled from mental or emotional illness who were among the 189 persons rehabilitated by the Hawaii general agency. The percentages in column (5) are based on the rehabilitants for whom the type of disability was reported--80,550 for the U.S. and 4,113 for Region IX. Data for some States involve sampling with expansion to 100% completeness.

c/ Program operations started in August 1958.

Source: Closed Case Reports, Form R-9.

Prepared by: Division of Statistics and Studies
Office of Vocational Rehabilitation
U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Washington 25, D. C.
May 1961

Table S-40.--State vocational rehabilitation agencies: Number^{1/} of persons with psychoneuroses rehabilitated, by State, fiscal years ending June 30, 1956-1959

State	1956	1957	1958	1959
Total.....	1,230	1,398	1,555	^{2/} 1,635
Alabama.....	14	14	26	22
Alaska.....	0	1	0	0
Arizona.....	10	17	16	17
Arkansas.....	14	28	52	47
California.....	88	64	70	74
Colorado.....	8	10	18	22
Connecticut.....	64	78	75	53
Delaware.....	24	18	23	27
District of Columbia....	20	22	10	15
Florida.....	56	52	66	76
Georgia.....	58	57	81	99
Guam ^{3/}	-	-	-	0
Hawaii.....	5	5	0	(^{2/})
Idaho.....	2	1	1	0
Illinois.....	162	162	136	128
Indiana.....	4	20	12	28
Iowa.....	22	16	26	30
Kansas.....	5	6	0	4
Kentucky.....	4	16	4	4
Louisiana.....	18	14	20	18
Maine.....	2	1	9	9
Maryland.....	41	46	36	38
Massachusetts.....	16	18	18	34
Michigan.....	36	48	48	46
Minnesota.....	16	18	39	22
Mississippi.....	6	2	6	2
Missouri.....	20	16	24	26
Montana.....	3	11	5	7
Nebraska.....	10	26	38	12
Nevada.....	0	2	4	1
New Hampshire.....	6	5	3	2
New Jersey.....	4	18	24	30
New Mexico.....	2	2	4	5
New York.....	93	96	118	105
North Carolina.....	58	64	58	82
North Dakota.....	3	4	5	9
Ohio.....	4	12	6	34
Oklahoma.....	10	12	12	29
Oregon.....	30	22	44	20
Pennsylvania.....	84	118	134	112
Puerto Rico.....	4	2	6	10

Footnotes are on back of table.

Table S-40, continued

State	1956	1957	1958	1959
Rhode Island.....	8	16	17	30
South Carolina.....	10	10	8	17
South Dakota.....	4	1	3	3
Tennessee.....	38	48	42	22
Texas.....	14	14	12	26
Utah.....	9	5	14	15
Vermont.....	4	5	0	3
Virginia.....	10	32	24	36
Virgin Islands <u>4/</u>	-	-	0	0
Washington.....	16	24	23	24
West Virginia.....	62	72	110	122
Wisconsin.....	26	20	20	36
Wyoming.....	3	7	5	2

1/ Partially estimated--based on a 50% sample for the larger State agencies (100% for the smaller) expanded to 100% completeness.

2/ Excludes data for Hawaii, which are not available.

3/ Program operations started in August 1958.

4/ Program operations started in March 1957.

Source: Closed Case Reports, Form R-9.

Prepared by:
 Division of Statistics and Studies
 Office of Vocational Rehabilitation
 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
 January 1961

Washington 25, D. C.

Table S-41.--State vocational rehabilitation agencies: Number^{1/} of persons with psychoses rehabilitated, by State, fiscal years ending June 30, 1956-1959

State	1956	1957	1958	1959
Total.....	962	1,398	1,666	^{2/} 2,028
Alabama.....	6	16	16	26
Alaska.....	1	0	0	3
Arizona.....	24	33	33	33
Arkansas.....	16	38	60	58
California.....	48	24	22	36
Colorado.....	11	12	22	36
Connecticut.....	26	50	54	56
Delaware.....	13	10	26	37
District of Columbia...	15	27	18	27
Florida.....	16	14	34	34
Georgia.....	40	45	49	50
Guam ^{3/}	-	-	-	0
Hawaii.....	8	8	6	(^{2/})
Idaho.....	0	0	0	1
Illinois.....	24	58	86	80
Indiana.....	22	28	24	26
Iowa.....	16	26	48	52
Kansas.....	5	0	2	0
Kentucky.....	0	4	6	22
Louisiana.....	10	6	18	30
Maine.....	2	2	9	22
Maryland.....	28	50	52	28
Massachusetts.....	10	26	28	50
Michigan.....	10	30	46	46
Minnesota.....	12	42	50	64
Mississippi.....	12	8	4	10
Missouri.....	12	15	15	27
Montana.....	16	17	25	9
Nebraska.....	26	50	32	30
Nevada.....	2	0	0	0
New Hampshire.....	5	5	6	6
New Jersey.....	2	10	18	18
New Mexico.....	2	0	2	1
New York.....	161	221	201	286
North Carolina.....	21	16	25	11
North Dakota.....	4	6	1	6
Ohio.....	20	46	38	40
Oklahoma.....	22	12	16	31
Oregon.....	16	8	14	12
Pennsylvania.....	63	202	240	261
Puerto Rico.....	0	2	0	4

Footnotes are on back of table.

Table S-41, continued

State	1956	1957	1958	1959
Rhode Island.....	0	4	21	30
South Carolina.....	8	2	4	6
South Dakota.....	2	2	6	6
Tennessee.....	22	20	18	24
Texas.....	14	24	32	66
Utah.....	9	7	7	20
Vermont.....	5	3	9	40
Virginia.....	38	46	66	88
Virgin Islands <u>4/</u>	-	-	0	0
Washington.....	8	27	25	30
West Virginia.....	90	62	88	100
Wisconsin.....	18	22	28	46
Wyoming.....	1	12	16	3

1/ Partially estimated--based on a 50% sample for the larger State agencies (100% for the smaller) expanded to 100% completeness.

2/ Excludes data for Hawaii, which are not available.

3/ Program operations started in August 1958.

4/ Program operations started in March 1957.

Source: Closed Case Reports, Form R-9.

Prepared by:
 Division of Statistics and Studies
 Office of Vocational Rehabilitation
 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
 January 1961

Washington 25, D. C.

Table S-55.--State vocational rehabilitation agencies: Number 1/ of persons with personality, character, and behavior disorders rehabilitated, by State, fiscal years ending June 30, 1956-1959

State	1956	1957	1958	1959
Total.....	324	373	524	<u>2/</u> 929
Alabama.....	4	4	8	4
Alaska.....	0	0	0	0
Arizona.....	8	11	7	13
Arkansas.....	4	22	14	86
California.....	10	20	28	32
Colorado.....	13	14	26	26
Connecticut.....	20	18	20	30
Delaware.....	5	1	6	8
District of Columbia..	12	4	5	12
Florida.....	6	6	14	36
Georgia.....	7	6	7	20
Guam <u>3/</u>	--	--	--	0
Hawaii.....	2	0	1	(<u>2/</u>) 1
Idaho.....	0	0	0	1
Illinois.....	18	14	20	38
Indiana.....	12	10	14	18
Iowa.....	10	0	12	20
Kansas.....	1	0	0	0
Kentucky.....	0	2	0	4
Louisiana.....	4	18	28	26
Maine.....	1	0	2	7
Maryland.....	12	16	6	24
Massachusetts.....	4	0	4	12
Michigan.....	0	0	10	22
Minnesota.....	4	4	4	14
Mississippi.....	6	2	2	2
Missouri.....	4	11	6	14
Montana.....	2	3	3	6
Nebraska.....	6	12	12	8
Nevada.....	0	0	1	3
New Hampshire.....	0	0	3	1
New Jersey.....	2	4	12	10
New Mexico.....	1	0	1	1
New York.....	42	23	47	86
North Carolina.....	7	5	7	7
North Dakota.....	2	4	5	12
Ohio.....	10	2	4	12
Oklahoma.....	8	6	6	14
Oregon.....	4	16	16	14
Pennsylvania.....	13	45	65	62
Puerto Rico.....	0	2	0	4

Footnotes are on back of table.

Table S-55, continued

State	1956	1957	1958	1959
Rhode Island.....	2	1	10	22
South Carolina.....	0	2	0	3
South Dakota.....	1	2	4	4
Tennessee.....	8	18	2	16
Texas.....	2	0	4	12
Utah.....	2	5	6	26
Vermont.....	1	1	0	6
Virginia.....	10	8	8	24
Virgin Islands <u>4/</u>	--	--	1	2
Washington.....	4	8	15	29
West Virginia.....	22	18	28	56
Wisconsin.....	6	4	18	18
Wyoming.....	2	1	2	2

- 1/ Data for some States involve sampling, with expansion to approximate completeness. The fiscal year 1956 is the year ending June 30, 1956; and so on. Data for fiscal years 1956 through 1958 are limited to rehabilitants with disabilities classified as psychopathic personality. Data for fiscal year 1959 include those with disabilities classified as pathological personality; immature personality; alcoholism other than alcoholic psychoses; drug addiction other than that with psychoses; primary childhood behavior disorders; and other and unspecified personality, character, and behavior disorders excluding mental deficiency.
- 2/ Excludes data, which are not available, on any persons disabled from personality, character, and behavior disorders who were among the 189 persons rehabilitated by the Hawaii general agency.
- 3/ Program operations started in August 1958.
- 4/ Program operations started in March 1957.

Source: Closed Case Reports, Form R-9.

Table B.--Disabled persons served and those rehabilitated through the
OVR-sponsored research and demonstrations projects in
fiscal year ending June 30, 1960--

All projects and those for the mentally ill

	:	:	Projects for
	:	All	the mentally ill <u>a/</u>
	: projects:	:	Percent of
	:	Number	: all projects
Number of projects reporting.....	<u>b/ 134</u>	<u>21</u>	<u>16</u>
Number of persons served: <u>Total</u>	<u>15,611</u>	<u>2,597</u>	<u>17</u>
Clients of State V.R. agencies.....	5,624	780	14
Other disabled persons.....	9,987	1,817	18
Number of persons rehabilitated: <u>Total</u> ...	<u>3,786</u>	<u>553</u>	<u>15</u>
Clients of State V.R. agencies.....	2,125	228	11
Other disabled persons.....	1,661	325	20

a/ Includes projects for the mentally or emotionally ill.

b/ There were 4 additional projects serving disabled people during fiscal year 1960 whose reports had not arrived in time to be included in this summary. None of the projects were ones designed to serve the mentally ill. Projects not specifically designed to serve disabled people directly are excluded from this table.

Source: Form OVR-16

Prepared by: Division of Statistics and Studies
Office of Vocational Rehabilitation
July 1961

LIST OF 49 EXTENSION AND IMPROVEMENT PROJECTSServing the Mentally Ill^{1/}1955 - 1961

<u>State</u>	<u>Project</u>	<u>Fiscal Year</u>	<u>Federal Grant</u>
<u>Alaska</u>	Establishment of branch office in Seattle, Washington (includes working with patients at Morningside Mental Hospital in Portland)	1956 1957	\$5,000 5,000
<u>Arizona</u>	Vocational rehabilitation counselor for the mentally ill at the Arizona State Hospital	1955	525
	Counselor for the mentally and emotionally ill at the Southern (Phoenix) District Office	1959 1960 1961	3,206 3,750 3,150
<u>Arkansas</u>	Establishment of a rehabilitation center for the mentally ill at the State Hospital in Little Rock	1958 1959 1960	15,761 15,076 14,805
<u>Colorado</u>	Denver Mental Project (improvement of services to the mentally ill; referrals made by Colorado State Hospital)	1957 1958 1959	3,261 5,955 9,029
	Improvement of services to the mentally ill by employment of consultants and establishment of new district office to serve only the mentally ill	1960 1961	14,343 14,253
<u>Connecticut</u>	Extension of services to the tuberculous, mentally ill and mentally retarded by assignment of three counselors to handle caseload from five State TB sanatoria, three mental hospitals and two training institutions	1956 1957 1958	16,038 15,895 15,505
<u>Delaware</u>	In-hospital VR training at Delaware State Mental Hospital, Farnhurst (to provide personal adjustment training)	1957	5,000
	Improved services to special disability groups including the mentally retarded, mentally ill, homebound and the severely disabled	1960 1961	5,000 5,000
<u>Iowa</u>	An organized plan for extending and improving VR services provided individuals handicapped as a result of mental illness	1960 1961	12,648 17,869

1/ 14 of these also serve other disability groups.

<u>State</u>	<u>Project</u>	<u>Fiscal Year</u>	<u>Federal Grant</u>
<u>Kentucky</u>	Improvement of vocational rehabilitation services to the mentally disabled in cooperation with the Kentucky Department of Health	1958 1959 1960	\$14,573 12,090 14,539
<u>Maine</u>	Extension of vocational rehabilitation services of the emotionally ill by assignment of a counselor in Augusta	1958 1959 1960	5,422 8,041 7,981
<u>Massachusetts</u>	Organized plan for provision of vocational rehabilitation services to the emotionally disabled by assignment of a full-time counselor	1955 ^{1/} 1956 1957 1958	2,085 9,570 15,907 15,611
	Services to emotionally disabled through the establishment of training programs for selected patients of State mental hospitals	1959	10,743
<u>Michigan</u>	Special project for the mentally ill as well as the mentally retarded by providing special administrative and consultative services at the State level for training and placement	1959 1960 1961	11,294 11,422 11,790
<u>Minnesota</u>	Establishment of workshop - Goodwill Industries (serving the mentally ill and mentally retarded)	1957	14,558
	Establishment of community center project for rehabilitation of mental hospital patients sponsored by Greater Minneapolis Council of Church Women	1959 1960	4,056 5,020
<u>Missouri</u>	**To provide psychiatric consultative services to agency staff serving emotionally disturbed clients	1955	6,394
	Psychiatric consultant to assist agency staff with respect to mental aspects of program services	1957 1958	1,350 1,575
	Services to special disability group including emotionally handicapped through use of facilities at Rehabilitation Institute in Kansas City	1958 1959 1960	9,000 9,000 9,000
	Supervisor of services to the mentally ill and mentally retarded	1960 1961	6,792 9,745
<u>Nebraska</u>	Services to the mentally ill by assignment of counselor to screen cases in mental institutions	1955 1956 1957	2,805 3,636 4,950

^{1/} No expenditures made in Fy 1955.

** Denotes sponsorship by the agency for the blind.

<u>State</u>	<u>Project</u>	<u>Fiscal Year</u>	<u>Federal Grant</u>
<u>New Hampshire</u>	Assignment of counselor to develop program of service for mental patients (Concord State Hospital) and includes alcoholics from clinic	1956	\$ 5,000
		1957	5,000
<u>New Jersey</u>	Extension and improvement of services to the mentally ill clients in Hudson County (assignment of a counselor)	1958	2,293
		1959	4,159
		1960	6,215
	A project for extension and improvement of services to hospitalized mental patients (assignment of counselor at Trenton State Hospital)	1960	3,218
		1961	6,601
	Extension and improvement of services of the Goodwill Industries of Northern New Jersey, Jersey City (provides testing of work tolerance and selective placement opportunities)	1960	4,172
<u>New Mexico</u>	Extension and improvement of services of the Occupational Center of Union County, Inc. (serves the cerebral palsied, mentally ill and mentally retarded)	1960	1,889
<u>New Mexico</u>	Rehabilitation of the mentally ill (assignment of counselor at the New Mexico State Hospital)	1960	7,059
<u>New York</u>	Altro Health and Rehabilitation Services, Inc. (providing training in clerical trades for tuberculous, cardiac and psychiatric patients)	1956 ^{1/}	9,820
		1957	11,283
		1958	5,940
		1959	1,950
	Skills Unlimited, Inc. of East Islip (provides on-the-job training and sheltered employment - serves mentally ill and mentally retarded)	1959	11,704
		1960	7,684
		1961	9,691
<u>North Dakota</u>	Establishment of a district office at Bismarck (providing services to the mentally ill)	1955	3,150
		1956	4,211
		1957	460
	Assignment of counselor at State mental hospital	1957 ^{2/}	2,170
		1959	5,491
		1960	5,449
		1961	5,148

^{1/} No expenditures made in FY 1956.

^{2/} Project was not initiated until 1959

<u>State</u>	<u>Project</u>	<u>Fiscal Year</u>	<u>Federal Grant</u>
<u>Ohio</u>	Toledo State Hospital (assignment of counselor to serve the mentally ill)	1958	\$ 1,574
		1959	4,590
		1960	5,837
	Columbus State Hospital (assignment of counselor to serve the mentally ill)	1958	2,646
		1959	5,127
		1960	6,250
	Cleveland State Hospital (assignment of counselor to serve the mentally ill)	1958	3,520
		1959	5,139
		1960	5,817
<u>Oklahoma</u>	Development of rehabilitation services for patients of two mental hospitals (assignment of counselor at Eastern Oklahoma Hospital, Vinita; and one at Western Oklahoma Hospital, Fort Supply)	1958	19,425
		1959	19,416
		1960	19,156
<u>Oregon</u>	Counselor assigned to the Oregon State Hospital, Salem (to serve the mentally ill)	1957	6,027
		1958	9,713
		1959	9,814
<u>Pennsylvania</u>	Extend vocational rehabilitation services for psychiatric patients of mental hospitals (by assignment of counselors)	1955	10,312
		1956	20,738
		1957	37,725
<u>South Dakota</u>	Assignment of counselor at the State Mental Hospital at Yankton (to serve the mentally ill)	1955	4,532
		1956	2,696
		1957	4,800
<u>Tennessee</u>	Assignment of a counselor to provide services to the mentally and emotionally ill patients at the Central State Hospital	1956	21,000
		1957	21,000
<u>Texas</u>	Establishment of a facility for educable physically and mentally handicapped (including the mentally retarded) in cooperation with the Dallas Independent School District	1959	11,745
		1960	14,813
		1961	12,000
<u>Utah</u>	Rehabilitation services to mental cases at the State Mental Hospital in Provo and the mentally retarded from the American Fork Training School (by assignment of a counselor)	1957	2,987
		1958	7,051
		1959	7,256
	Specialized rehabilitation services for alcoholics (assignment of counselor and part-time consultant in cooperation with the Utah Rehabilitation Center)	1960	7,251

<u>State</u>	<u>Project</u>	<u>Fiscal Year</u>	<u>Federal Grant</u>
<u>Vermont</u>	Expansion of Goodwill Industries of Vermont, Inc. (to serve severely disabled, mentally ill and the mentally retarded)	1955 ^{1/} 1956 1957	\$ 5,000 2,100 3,125
	Establishment of Rehabilitation House (a facility for the mentally ill and the mentally retarded)	1956 1957	2,900 1,875
	**Psychiatric consultation for blind clients	1961	193
<u>Washington</u>	Improvement of services for the mentally ill patients at the Western State Hospital (by assignment of a counselor)	1959 1960 1961	15,160 23,160 23,160
<u>West Virginia</u>	Improvement of services to the mentally and emotionally ill (full-time counselors assigned to Weston, Spencer, Huntington, and Lakin State Hospital, and at St. Mary's Training School)	1955	17,813
<u>Wisconsin</u>	Employment adjustment center for emotionally ill in cooperation with Jewish Vocational Service	1958 1959 1960	22,500 22,500 22,500

^{1/} No expenditures made in 1955.

** Denotes sponsorship by the agency for the blind.

Five Expansion Projects Serving the Mentally IllFiscal Years 1956 and 1957

<u>State</u>	<u>Title of Project</u>	<u>Fiscal Year</u>	<u>Federal Grant</u>
Alabama	Establishment of a mental health center	1957	\$11,355
Connecticut	Counseling services for patients at Undercliff Hospital	1957	2,000
Hawaii	Establishment of a facility	1956	2,027
Puerto Rico	Establishment of an adjustment and evaluation center for mentally ill	1956	12,889
Texas	Adjustment Center for recently discharged mentally ill patients	1957	1,200

Prepared by:
Division of State Plans
and Grants
June 8, 1961

TRAINING GRANTS IN THE FIELD OF
REHABILITATION OF THE MENTALLY ILL
FISCAL YEAR 1961*

<u>Sponsor</u>	<u>State</u>	<u>Amount</u>
American Occupational Therapy Association	New York	\$12,000**
University of Pennsylvania School of Occupational Therapy	Pennsylvania	8,129
Boston University	Massachusetts	5,015
Arkansas State Hospital	Arkansas	2,495
University of South Carolina	South Carolina	<u>4,264</u>
	Total	\$31,903

TRAINING GRANTS IN THE FIELD OF
REHABILITATION OF THE MENTALLY ILL
FISCAL YEAR 1960

<u>Sponsor</u>	<u>State</u>	<u>Amount</u>
Boston University	Massachusetts	\$ 7,441
University of Colorado	Colorado	2,971
Fountain House	New York	7,236
University of Nebraska	Nebraska	3,385
Richmond Professional Institute	Virginia	3,454
University of Utah	Utah	5,268
University of Wisconsin	Wisconsin	<u>11,118</u>
	TOTAL	\$40,873

* Through May 12, 1961

** Provides for a Psychiatric Occupational Therapy Consultant on Rehabilitation to Schools of Occupational Therapy and Clinical Affiliations.

Prepared by:
Division of Training

TRAINING GRANTS IN THE FIELD OF
REHABILITATION OF THE MENTALLY ILL
FISCAL YEAR 1959

<u>Sponsor</u>	<u>State</u>	<u>Amount</u>
Boston University	Massachusetts	\$ 2,798
Fountain House	New York	8,968
Richmond Professional Institute	Virginia	<u>3,036</u>
	TOTAL	\$14,802

TRAINING GRANTS IN THE FIELD OF
REHABILITATION OF THE MENTALLY ILL
FISCAL YEAR 1958

<u>Sponsor</u>	<u>State</u>	<u>Amount</u>
Boston University - Emotionally Disturbed	Massachusetts	\$ 2,864
Richmond Professional Institute	Virginia	2,495
University of Vermont	Vermont	<u>14,703</u>
	TOTAL	\$20,062

TRAINING GRANTS IN THE FIELD OF
REHABILITATION OF THE MENTALLY ILL
FISCAL YEAR 1957

<u>Sponsor</u>	<u>State</u>	<u>Amount</u>
Duke University	North Carolina	\$ 2,783
University of Illinois	Illinois	7,705
Vanderbilt University	Tennessee	2,972
University of Kansas	Kansas	<u>9,779</u>
	TOTAL	\$23,239

Prepared by:
Division of Training

TRAINING GRANTS IN THE FIELD OF
REHABILITATION OF THE MENTALLY ILL
FISCAL YEAR 1956

<u>Sponsor</u>	<u>State</u>	<u>Amount</u>
Southern Methodist University	Texas	\$ 7,367
University of Colorado	Colorado	5,852
San Jose State College	California	<u>11,298</u>
	TOTAL	\$24,517

Prepared by:
Division of Training

TRAINING GRANTS IN THE FIELD OF
REHABILITATION OF THE MENTALLY ILL
FISCAL YEAR 1955

<u>Sponsor</u>	<u>State</u>	<u>Amount</u>
*Saint Elizabeths Hospital	Washington, D. C.	\$ 6,763

* Traineeships paid directly from Central Office -
Salary and Expense Appropriation.

RESEARCH AND DEMONSTRATION PROJECTS CONCERNED
WITH MENTAL ILLNESS AND PERSONALITY DISORDERS

Current to June 30, 1962

Grant Awards by Fiscal Year

	<u>1956</u>	<u>1957</u>	<u>1958</u>	<u>1959</u>	<u>1960</u>	<u>1961</u>	<u>1962</u>
Total Funds for Projects (Other than Selected Demonstrations)	\$79,305	\$253,592	\$259,774	\$420,335	\$529,979	\$886,773	\$936,533
<u>Project</u>							
<u>Number</u>							
55	Massachusetts Mental Health Center, Boston	47,265	48,523	48,744	50,366	52,933	
83	Washburn University of Topeka, Kansas	32,040-s					
114	Massachusetts Association for Mental Health, Boston		5,800				
122	Rehabilitation Planning Committee, Santa Clara, California		18,050	19,925	21,150		
142	Rehabilitation Center of Greater St. Louis, Missouri		15,054			21,313	
153	State Project Committee, Salem, Oregon		89,550		82,857	81,452	
176	Research Foundation for Mental Hygiene New York, New York		25,900	24,800	21,670		

s - supplement included

Grant Awards by Fiscal Year

<u>Project Number</u>	<u>Project</u>	<u>1956</u>	<u>1957</u>	<u>1958</u>	<u>1959</u>	<u>1960</u>	<u>1961</u>	<u>1962</u>
179	Massachusetts Association for Mental Health, Boston		\$11,300					
182	Butler Health Center Providence, Rhode Island		39,415	39,415	39,415			
155	Johns Hopkins University Baltimore, Maryland			20,590	21,919			
180	Vermont State Hospital Waterbury, Vermont			30,000	30,000	30,000		
256	University of Utah, Salt Lake City, Utah			29,889	34,386-s			
284	Volunteers of America of Los Angeles, Inc., California			25,886-s	31,090	41,118		
297	Georgia Division of Voca- tional Rehabilitation Atlanta, Georgia			20,525		21,568	22,153	30,000
334	Jewish Vocational Service Newark, New Jersey				30,050	30,800	33,027	32,192

s - supplement included

Grant Awards by Fiscal Year

<u>Project Number</u>	<u>Project</u>	<u>1956</u>	<u>1957</u>	<u>1958</u>	<u>1959</u>	<u>1960</u>	<u>1961</u>	<u>1962</u>
403	Connecticut Commission on Alcoholism New Haven, Conn.				\$23,366			
424	Columbia University, New York, N.Y.				5,566			
426	World Federation for Mental Health, New York, New York				28,500		\$43,450	\$33,500
405	University of Minnesota Medical School, Minneapolis, Minnesota					\$38,008	48,903	52,289
418	National Council on Alcoholism, New York, New York					39,040	45,100	44,100
449	Jewish Vocational Service Chicago, Illinois					7,250-p		
406	Central State Hospital Lakeland, Kentucky					19,571		16,490
487	Jewish Family & Children's Service, Denver, Colo.					31,050	23,268	
505	Jewish Vocational Service & Community Workshop, Detroit, Mich.					27,096	29,276	30,200

p - publications award

Project Number	Project	Grant Awards by Fiscal Year					
		<u>1957</u>	<u>1958</u>	<u>1959</u>	<u>1960</u>	<u>1961</u>	<u>1962</u>
550	Butler Health Center, Providence, Rhode Island				\$52,960	\$52,960	
578	St. Vincent's Hospital of the City of New York			35,820	36,863	\$37,950	
616	The Salvation Army, San Francisco, California				46,290	53,140	
623	Berman School, Inc., Freeport, New York			25,800		30,410	
640	Florida Alcoholic Rehabilitation Program, Avon Park, Florida				31,271		
641	Jewish Vocational Service, Chicago, Ill.				57,702	62,812	
681	Minneapolis Public Schools				32,345	28,092	
685	The Children's Village, Dobbs Ferry, New York				34,619	48,018	
689	Goodwill Industries of Forth Worth, Texas				21,594	16,000	
712	Just One Break, New York, New York				16,168	16,818	

<u>Project Number</u>	<u>Project</u>	<u>1956</u>	<u>1957</u>	<u>1958</u>	<u>1959</u>	<u>1960</u>	<u>1961</u>	<u>1962</u>
713	Massachusetts Mental Health Center, Boston						\$27,150	
716	Massachusetts Association for Mental Health, Boston					25,493-s		\$26,496
726	University of California, Los Angeles						34,167	33,292
754	Minnehaha Guidance Center, South Dakota						44,090	
778	Georgia Division of Vocational Rehabilitation, Atlanta						57,605	
784	Arkansas Rehabilitation Service Little Rock						50,000	
792	University of Pittsburgh						44,219	39,100
817	Horizon House, Inc., Philadelphia, Pa.							80,089
837	Conard House, Inc., San Francisco							28,560
843	University of Michigan							76,673
848	Worcester State Hospital, Mass.							42,085
1035	Brandeis University, Waltham, Mass.							4,370

s-supplement included

SELECTED DEMONSTRATION PROJECTS CONCERNED WITH
MENTAL ILLNESS AND PERSONALITY DISORDERS

Current to June 30, 1962

<u>Projects Number</u>	<u>Project</u>	<u>Grant Awards by Fiscal Year</u>			
		<u>1958</u>	<u>1959</u>	<u>1960</u>	<u>1961</u> <u>1962</u>
	Total Funds . .	\$106,600	\$120,680	\$263,113	\$250,967 \$281,105
200	The Rehabilitation Institute Kansas City, Missouri	34,850	31,620	34,520	
275	Indianapolis Goodwill Industries Indiana	25,282	22,275	18,700	13,000 23,575
306	Jewish Vocational Service Cincinnati, Ohio	25,795	27,670	35,955	
313	Opportunity Center, Inc. Wilmington, Delaware	20,673		15,276	15,050 13,930
355	Jewish Employment and Vocational Service, Philadelphia, Pa.		39,115	41,350	41,250 13,750
500	The Rehabilitation Center Evansville, Indiana			28,500	31,620 28,620
566	Kentucky Bureau of Rehabilitation Service, Frankford, Kentucky			39,042	23,072
571	State Board of Vocational Education Charleston, West Virginia			49,770	40,312 38,300

Grant Awards by Fiscal Year

<u>Project Number</u>	<u>Project</u>	<u>1958</u>	<u>1959</u>	<u>1960</u>	<u>1961</u>	<u>1962</u>
553	May T. Morrison Center for Rehabilitation, San Francisco California				\$39,825	\$42,554
630	St. Louis State Hospital St. Louis, Missouri				41,600	33,579
675	Goodwill Industries of El Paso, Texas				28,310	28,030
873	Springfield Goodwill Industries, Mass.					35,695

Published Final Reports on OVR-Supported Research
Projects in Psychiatric Rehabilitation*

<u>Project Number</u>	<u>Grantee Agency and Report Title</u>
55	Massachusetts Mental Health Center, Boston, Mass. <u>Kramer, Bernard M., Day Hospital: A Study of Partial Hospitalization in Psychiatry.</u> New York: Grune and Stratton, 1962.
180	Vermont State Hospital, Waterbury, Vt. <u>Brooks, George W., Project Director, The Vermont Story: Rehabilitation of Chronic Schizophrenic Patients,</u> 105 pp; January 1961.
182	Butler Health Center, Providence, Rhode Island. <u>Hyde, Robert W., Bockoven, J. Sanbourne, Project Director, Pfautz, Harold W., and York, Richard H., Milieu Rehabilitation for Physical and Mental Handicaps,</u> 1962.
284	Volunteers of America of Los Angeles, Los Angeles, California. <u>Hart, Walter C., Project Director, Potential for Rehabilitation of Skid Row Alcoholic Men,</u> 1961.

* A Bibliography of Reports Resulting from OVR Research and Demonstration Projects is in preparation. It will list, in addition to Final Reports, Journal Articles resulting from the projects.

July, 1962

FACILITIES SERVING THE MENTALLY ILL
DEVELOPED THROUGH EXTENSION AND IMPROVEMENT PROJECTS

<u>State</u>	<u>Project</u>	<u>Fiscal Year</u>	<u>Federal Grant</u>
Arkansas	Establishment of a rehabilitation center for the mentally ill at the State Hospital in Little Rock	1958	\$15,761
		1959	15,076
		1960	14,805
Delaware	In-hospital VR training at Delaware State Mental Hospital, Farnhurst (to provide personal adjustment training)	1957	5,000
Minnesota	Establishment of workshop - Goodwill Industries (serving the mentally ill and the mentally retarded)	1957	14,558
Minnesota	Establishment of community center project for rehabilitation of mental hospital patients sponsored by Greater Minneapolis Council of Church Women	1959	4,056
		1960	5,020
New York	Altro Health and Rehabilitation Services, Inc. (providing training in clerical trades for tuberculous, cardiac and psychiatric patients)	1956 ^{1/}	9,820
		1957	11,283
		1958	5,940
		1959	1,950
New York	Skills Unlimited, Inc. of East Islip (provides on-the-job training and sheltered employment - serves mentally ill and mentally retarded)	1959	11,704
		1960	7,684
		1961	9,691
Texas	Establishment of a facility for educable physically and mentally handicapped (including the mentally retarded) in cooperation with the Dallas Independent School District	1959	11,745
		1960	14,813
		1961	12,000
Vermont	Expansion of Goodwill Industries of Vermont, Inc. (to serve severely disabled, mentally ill and the mentally retarded)	1955 ^{2/}	5,000
		1956	2,100
		1957	3,125
Vermont	Establishment of Rehabilitation House (a facility for the mentally ill and the mentally retarded)	1956	2,900
		1957	1,875

1/ No expenditures made in FY 1956.

2/ No expenditures made in FY 1955.

Hill-Burton Projects for Mentally Ill

- Up to January 1961 -

<u>Name of Facility</u>	<u>Location</u>	<u>In-patient</u>	<u>Out-patient</u>	<u>AGE GROUPS SERVED</u>	
				<u>Under 16</u>	<u>Over 16</u>
New Mexico State Hospital	Las Vegas, N.Mex.	X		X	X
Hillcrest Psychiatric Center	Tulsa, Okla.		X	X	X
Tulane University School of Medicine	New Orleans, La.	X			X
East Louisiana State Hospital	Jackson, Miss.	X		X	X
Lutheran Hospital	Omaha, Neb.	X	X	X	X
Minnehaha Guidance Center	Souix Falls, S.D.		X	X	X (Mental Health and day care program)
Arizona State Hospital	Phoenix, Ariz.	X	X	X	X

List of Rehabilitation Facilities Readily Identifiable
as Serving the Mentally Ill and the Mentally Retarded
Established under Section 2 of the V.R. Act 1/

<u>State</u>	<u>Purpose</u>	<u>Fiscal Year</u>	<u>Federal and State Expenditures</u>
<u>Arkansas</u>			
Arkansas DVR	Rehabilitation Center for mentally ill.	1957 1958	\$225,267 52,242
<u>Colorado</u>			
Colorado State Hospital, Pueblo	Vocational adjustment addition.	1960	158,803
<u>Delaware</u>			
Delaware DVR	In-hospital training for the mentally ill.	1960	52
<u>Puerto Rico</u>			
State Mental Hospital, San Juan	Psychiatric Rehabilitation Facility.	1957	28,351
<u>South Carolina</u>			
State Hospital	Rehabilitation training for the mentally ill.	1959 1960	31,010 3,521
<u>Tennessee</u>			
Western State Hospital Bolivar	Facility for the mentally and emotionally ill.	1958	3,102
Central State Hospital	Mentally ill.	1960	61,656
<u>Vermont</u>			
Rehabilitation House	Serving mental patients.	1958 1959	13,388 9,575
<u>West Virginia</u>			
Huntington State Hospital	Mentally ill.	1959	16,637
<u>Wisconsin</u>			
Department of Public Assistance	Evaluates ability and aptitude.	1960	2,554
Mendota State Hospital <u>1/</u> Since specific reporting of these items has not been required, this number may actually be higher.			

Prepared by:
Division of State Plans
and Grants
June 8, 1961

Federal Share of Cost of Rehabilitating Persons With
Mental Illness for the Grants to States Program

Fiscal Years 1956 - 1962^{1/}

<u>Year</u>	<u>Number Rehabilitated</u>	<u>Federal Share of Cost</u>
<u>Mental Illness (Total)</u>		
1956	2,516	1,225,000
1957	3,169	1,650,000
1958	3,745	2,100,000
1959	4,592	2,650,000
1960	5,300	3,000,000
1961 (Est.)	5,800	3,400,000
1962 (Est.)	6,550	3,900,000
<u>Psychosis</u>		
1956	962	470,000
1957	1,398	730,000
1958	1,666	950,000
1959	2,028	1,170,000
1960	2,400	1,400,000
1961 (Est.)	2,700	1,600,000
1962 (Est.)	3,200	1,900,000
<u>Psychoneurosis</u>		
1956	1,230	600,000
1957	1,398	730,000
1958	1,555	875,000
1959	1,635	940,000
1960	1,800	1,000,000
1961 (Est.)	1,900	1,100,000
1962 (Est.)	2,050	1,200,000
<u>Other Nervous and Mental Disorders</u>		
1956	423	155,000
1957	373	190,000
1958	524	275,000
1959	929	540,000
1960	1,100	600,000
1961 (Est.)	1,200	700,000
1962 (Est.)	1,300	800,000

^{1/} Fiscal Years 1956 and 1957 include the expansion grant program.

Prepared by:
Division of State Plans and Grants
June 8, 1961



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